INTO THE 21st CENTURY

ONTARIO PUBLIC HOSPITALS

Report of the Steering Committee,
Public Hospitals Act Review

February 1992

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Ontario

Ministry of Health / Ministère de la Santé

Institutional Health Division
7th Floor, 15 Overlea Blvd.
Toronto, Ontario
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February, 1992

Honourable Frances Lankin
Minister of Health
10th Floor, Hepburn Block
Queen's Park
Toronto, Ontario
M7A 2C4

Dear Minister:

It gives me great pleasure to submit to you, the Report of the Steering Committee, Public Hospitals Act Review.

In presenting this document, I would like to acknowledge the tireless dedication of the members of the Steering Committee and task groups, and to thank them for their many hours of time, their ideas and their judgement.

The committee has from its inception, under the chairmanship of Jay Kaufman, tried to use the principle of consensus as the method of arriving at recommendations. In large part, consensus has been achieved on most issues. However, consensus does not imply unanimity. While the report does not reflect the individual views of all of its members, it does attempt however to convey a balanced discussion of the issues.

The report recommends that a new Public Hospitals Act be developed. The committee respectfully submits the findings and recommendations for your consideration and trusts that they will assist the government in establishing legislation for the organization and operation of Ontario hospitals into the 21st century.

Sincerely,

Ronald T. Sapsford md.

Ronald T. Sapsford
Chair
Steering Committee
Public Hospitals Act Review

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Ontario Public Hospitals

Executive Summary

The Context for Change

The Steering Committee for the Review of the Public Hospitals Act was established to carry out a comprehensive review of the Public Hospitals Act and advise the Minister of Health on changes to the Act which would enable public hospitals to respond effectively to contemporary and future health needs in Ontario. The Committee was comprised of 26 individuals selected to bring the perspectives of consumers, health professionals, hospital and health facilities, management and government.

A contemporary Public Hospitals Act must accommodate a number of circumstances not envisaged when it was first proclaimed in 1931. The size and characteristics of the Ontario population are vastly changed, as are the nature of health care and of the hospital, the increasing complexity of hospital management and operations and the movement toward a more accountable and better managed provincial health care system. A comprehensive legislative framework is needed to take Ontario's public hospitals into the 21st century. This legislative framework must look back to what should be preserved and protected, as well as forward to what should be changed.

Premises and Principles

The Steering Committee developed a set of premises and principles upon which its recommendations are based. The vision these premises and principles embodies requires that the Public Hospitals Act be rewritten anew rather than revised.

The first premise is that the thrust of legislation should be enabling rather than prescriptive. The prescriptive components of the legislation should be directed to ensuring that the responsibilities of the hospital are defined and the hospital board is accountable for fulfilling them. Within this prescriptive framework, the legislation should provide the hospital with freedom and flexibility to organize its response to the needs of the communities it serves as effectively as it can.

The second premise is that the Public Hospitals Act should support the provincial government's strategic thrust to develop a coordinated, integrated and balanced province-wide system of health services and facilities to replace the largely informal system currently in place.

The recommendations of the Steering Committee are based on six principles:

- accessible and equitable patient-centred treatment and care;
- responsiveness to community, regional and provincial needs;
- accountability to the patient and to the public;
- commitment to quality;
- management effectiveness; and
- respect for the values and traditions of the individual hospital.

In support of these principles, the new Public Hospitals Act should include a Declaration of Principles relating to the hospital's services, quality of care, responsibilities to the patient and collaboration with other providers in the health care system (3.01).[1]

The Social Contract

There is insufficient accountability and responsibility within Ontario's health care system. Explicit agreements are required between each hospital and the communities it serves regarding the role and responsibilities the hospital will assume. The concept is that of the social contract, a formal and accountable articulation of the informal understandings which currently exist between many hospitals and the communities they serve (4.01).

A hospital often serves several communities: those living close by as well as functional communities such as children or the elderly. Taken together, these communities represent the hospital's "composite community". In developing its social contract, the hospital must reach an understanding with its composite community on the hospital's responsibilities for programs and services, including education and research (4.04).

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[1]References in brackets are to the chapter and number of the relevant recommendations.

Negotiation of the social contract should take place within the planning framework of, and be facilitated by the district health council, or other provincially-mandated body (4.03). The social contract would be signed by the hospital and the Ministry of Health acting on behalf of the composite community, on the advice of the district health council. Hospitals should not be permitted to alter unilaterally programs, services or volumes set out in the social contract. The Ministry of Health will need to put in place mechanisms and procedures for the development and implementation of social contracts in each district or region (4.02).

In instances where the various parties negotiating a contract find themselves unable to come to agreement among themselves, the district health council would recommend to the Minister that the matter be referred to a Social Contract Conciliation Panel (4.05).

Governance

Accountability. The Public Hospitals Act should establish and ensure accountability of the hospital to its patients, the public and the government. Each hospital should be separately incorporated as a not-for-profit institution which focusses on the diagnosis, treatment and care of illness, disability and trauma on an in-patient and out-patient basis (5.01).

Responsibilities of Governance. It is in the public interest that all hospital boards and other stakeholders have a common understanding of what is meant by hospital governance and of the distinction between governance and management (5.02). Governance should be defined in the Public Hospitals Act as the exercise by the hospital's board of directors of authority, direction and control over the hospital. The fundamental responsibilities of the hospital board are to ensure that the hospital fulfills its purposes and principles, social contract and its objectives for patient care, management, quality of programs and services, fiscal integrity and long-term viability (5.03, 5.04). Management's responsibility is to develop and implement the strategies and programs to achieve the principles, purposes, goals and objectives set by the board.

There are shades of grey separating governance from management. The difference between them, however, is that the board's authority derives from both the hospital corporation and the community, whereas management's authority derives from the board to which it is accountable. Procedures should be developed to enable the hospital corporation and the community to

assess the effectiveness of the hospital's governance and management, and to provide a basis for public scrutiny of the hospital's fulfillment of its social contract (6.18).

Principles of Board Membership. The tradition in Ontario of voluntary governance should be continued. The hospital is a public institution with the primary corporate purpose of serving the patient and the community. Board membership should be drawn widely to reflect the functional communities the hospital serves, and to provide the skills the board requires to meet its responsibilities (5.10, 5.11).

Members of the board should not have interests which may conflict or be perceived to conflict with the hospital's corporate purposes and should be distanced from vested interests within the hospital. Therefore, no person appointed to a hospital's professional staff or employed by a hospital should serve on that hospital's board of directors (5.12).

Advisory Councils. It is essential that the board of directors and all professional and other hospital staff and the community have full and free access to each other on all aspects of hospital governance. Each hospital board should establish and ensure the effective operation of at least these three advisory councils (5.13, 5.14):

- Community Advisory Council, to extend the board's access to the hospital's functional communities, community organizations and other providers;
- Professional Advisory Council, consisting of representation from all regulated health professionals on the staff of the hospital; and
- Employee Advisory Council, consisting of representatives of those employees who are not members of a regulated health profession.

Accountability of the Board. The Public Hospitals Act should specify what the hospital board of directors is accountable for and to whom. The issues of accountability speak to the board's responsibility to achieve balance among the diverse interests of the many constituencies to which it is responsible within the hospital, the community and the wider health care system.

Management

The Public Hospitals Act should establish a legislative framework for management of the hospital and for the establishment of management structures and processes which integrate the many facets of the hospital into an effective, cohesive and well-managed totality.

Responsibilities of Management. Management's primary function, under the policies and direction of the board, is to ensure the effective and efficient delivery of high quality and appropriate hospital services. Management acts on behalf of, and is accountable to, the board for its activities (6.01, 6.02). To fulfill its responsibilities, management must put in place structures and processes for strategic planning, including development of the social contract, operational planning, budgeting, operations management and control, fiscal management, quality management and reporting to the board.

Ancillary Services. Hospitals should also be entitled to carry out ancillary activities which are consistent with the service objectives of the hospital, are based on sound business principles and contribute to its financial position (6.15). The Public Hospitals Act should allow hospitals to carry out entrepreneurial financing plans, within defined thresholds, provided they do not jeopardize the long-term viability of the hospital (6.14).

Managing Access to Hospital Resources. Management's strategy for fulfilling the hospital's mission and social contract should include a clinical human resource plan specifying the mix, number and types of regulated health professionals required and the staging of their appointments or employment (7.08). The Public Hospitals Act should guarantee the right of regulated health professionals to apply for appointment and require the hospital to respond to such applications (7.10).

The board of directors bears ultimate accountability, operationally delegated to management, for appointments and privileges (7.07). The Act should stipulate that appointments, reappointments and privileges are made within the framework of the hospital's social contract and clinical human resource plan (7.09). These should be key instruments in dealing with applications for appointments and privileges. The Act should state that the hospital may decline an initial application for appointment on valid and reasonable human resource grounds (7.12); and, with

reasonable notice, may restrict or terminate privileges or decline reappointment on these grounds (7.13).

The Act should also make clear that management, not the board of directors, is responsible for suspensions, revocations of appointments and modifications of privileges because of its primary responsibilities for ensuring quality, continuity and safety of care to the patient (7.11). The Act should restrict the grounds for the immediate suspension, alteration or revocation of privileges in mid-term to questions of competence and conduct where there is clear and compelling evidence of risk to patients (7.14). Modifications to privileges on these grounds should continue in effect pending appeal (7.15).

Organizational Structure. The distinction in the current Public Hospitals Act between clinical and management issues has become largely artificial; it serves to isolate medical and other clinical staff from structured involvement in management decisions. The current arrangements should be replaced by a system in which both clinical and operational decisions are made within unified management processes operating within a unified management structure directed by the chief executive officer (CEO) (6.20).

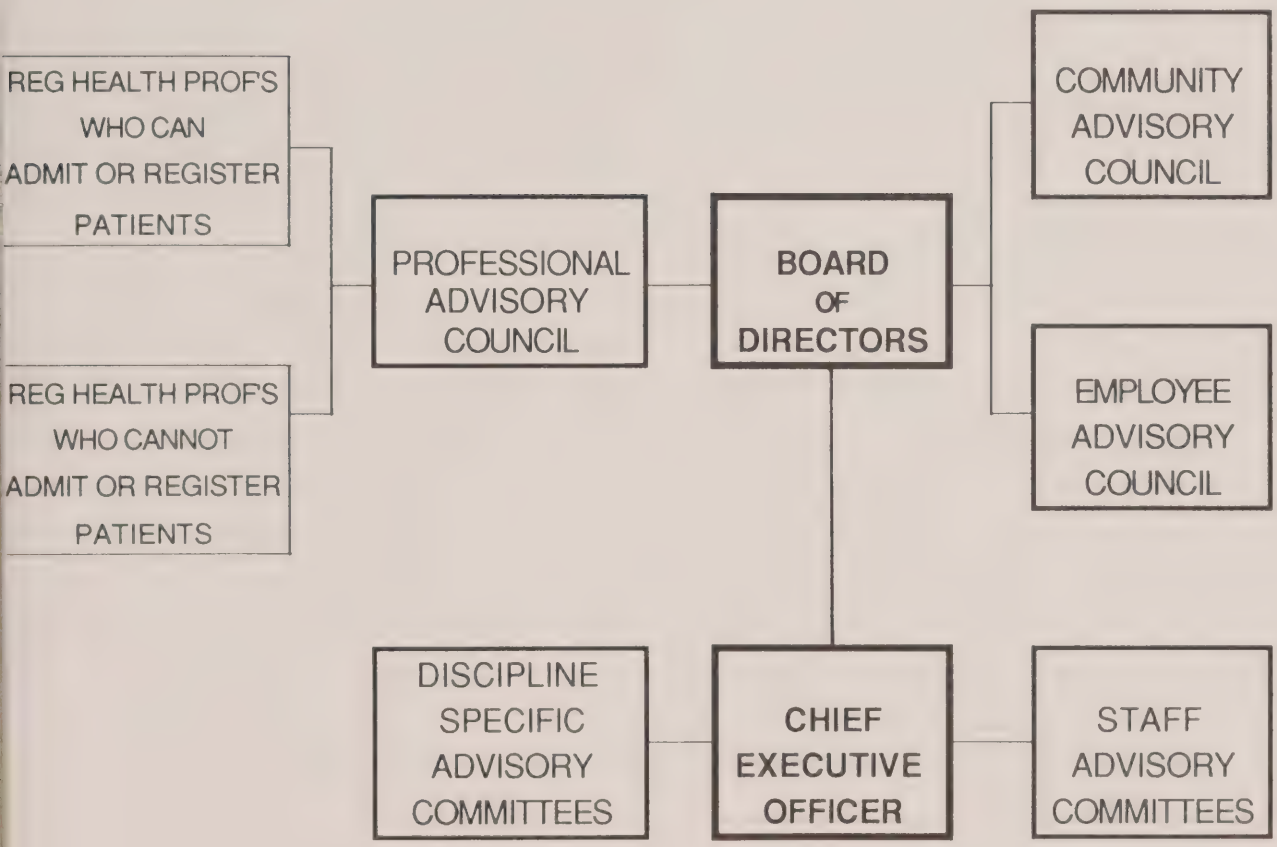
The Act should not define the hospital's management structure below the chief executive officer (6.21). The CEO should be held responsible for ensuring that the hospital's management structure and processes promote accountability, participation and communication among regulated health professionals and other hospital staff (6.19). The Act should also require at least one corporate officer to be responsible, with the CEO, for the quality of care and utilization of resources provided by individual professionals (6.25). The board should be responsible for appointing the CEO, and other corporate officers upon the recommendation of the CEO (6.24).

Advisory Committees to Management. The Public Hospitals Act should specify a committee structure advisory to management. Regulated health professionals and other staff should be represented on these multi-disciplinary advisory committees to deal with such matters as (6.27):

- quality improvement, including quality assurance, utilization management and clinical protocols;

HOSPITAL ORGANIZATION STRUCTURE

ADVISORY COUNCILS
AND
ADVISORY COMMITTEES



- pharmacy and therapeutics;
- ethics;
- clinical records;
- resource allocation; and
- clinical human resource planning.

In addition, discipline-specific committees advisory to management should be established for each regulated health profession within the hospital to deal with (6.28):

- credentialling;
- quality of care;
- peer review;
- rules and regulations; and
- discipline.

Appointments and Privileges

The Public Hospitals Act should provide a legislative basis for equivalence in the hospital's treatment of regulated health professions and professionals.

Regulated health professionals should be entitled to apply for appointment to the hospital - that is, for access to its resources - without the approval or sponsorship of another regulated health professional (7.01). The appointment of a regulated health professional would depend, among other criteria, upon the individual's scope of practice and the role defined for the hospital in its social contract. Regulated health professionals seeking hospital appointments may be asked to undertake certain obligations; however, the Act should not allow such obligations to include sharing of professional fees with, or payments to, the hospital (7.05).

The Act should define the term "appointment", when applied to a regulated health professional not employed by the hospital, as a status which grants the health professional access to the resources of the hospital (7.03). The degrees of access attendant on the appointment relate to the authority of the regulated health professional to carry out one or more of: admitting inpatients, registering outpatients and treating patients (7.02). The privileges of the regulated

health professional refer to these degrees of access and the specific procedures and therapies which the health professional is entitled to perform in the hospital in keeping with his or her scope of practice (7.04).

The credentialling requirements set out in the current Act should be broadened to include all regulated health professionals seeking employment, appointment or reappointment in the hospital (7.06).

Appointments and Hospital Employees. Regulated health professionals employed by the hospital would not be appointed, but would become members of the hospital staff by virtue of their employment. So long as there is a distinction between regulated health professionals appointed to the hospital staff and those employed by the hospital, there will necessarily be a difference between the "appointing" and the "hiring" procedures. It is important, however, that the two paths of engagement should be parallel, that professional requirements are equivalent and that the credentialling processes are equally rigorous.

Appeals. The hospital should not be entitled to change arbitrarily conditions of employment or appointment, or to alter privileges, or terminate or revoke appointments or employment. Such changes will, however, be necessary from time to time. The appeal processes need to be fair to both the professional and the hospital. The processes used to make these changes, and the processes for appeal of a negative decision, may differ according to the health professional's employment or appointment status; but they should be equivalent in the fairness and protection afforded the regulated health professional.

Hospital Appeal Board. The mandate of the Hospital Appeal Board should be expanded to include all regulated health professions (7.20); the size and composition of the Board should be expanded accordingly (7.21). In order to expedite the work of the Board, the Public Hospitals Act should provide for mandatory pre-hearing conferences for appeals (7.23), and for the appointment of a Vice-Chair (7.24).

Relations with Professional Bodies. There is a powerful public interest in ensuring that hospitals and the governing bodies of regulated health professionals inform each other on an on-going

basis of matters pertaining to the conduct and competence of individual regulated health professionals. The Public Hospitals Act should require the hospital to consult the appropriate professional governing body as part of the credentialling process for a professional seeking appointment or employment.

Also, the Act should require the hospital and professional governing bodies to notify each other automatically with respect to concluded proceedings involving an individual health professional with regard to altered privileges, revocation of appointment or failure to reappoint because of incompetence, negligence or misconduct. Because of the number of governing bodies, hospitals and regulated health professionals in the province, the Ministry of Health should develop mechanisms to facilitate the timely and appropriate exchange of information between hospitals and all governing bodies (7.26).

Quality

Quality is a primary concern of the hospital. It is important that the hospital's emphasis be on continually improving the quality of care and on incorporating this commitment into the culture of the organization. This requires a shift from focussing on after-the-fact inspections and audits to continuous quality improvement in all clinical support, managerial and governance functions.

The role of legislation in quality improvement should be one of empowerment rather than prescription. The Act should require hospital boards to incorporate continuous quality improvement in their mission statements (5.06), and establish quality improvement processes within the hospital (5.07). Hospitals should also be required to publish reports annually on their quality improvement activities and on the quality of their services and care (8.02). Within this framework, the hospital should have the flexibility to use the means it deems most effective for continuous quality improvement.

In order to ensure necessary data are available, the Public Hospitals Act should provide access to patients' health records to hospital staff designated by the board to be responsible for quality improvement, and limit accessibility to that purpose only (8.04). The Act should ensure that all materials and proceedings of the hospital's quality improvement committee are not admissible in legal proceedings (8.05). Similarly, individuals should be immune from testifying in court in connection with their activities on behalf of the quality improvement committees of the board and

management (8.06). The Act should protect hospital staff from liability for actions or statements made in good faith in the course of their participation in quality improvement processes and committees (8.07). Proceedings and records of the quality improvement committee should not be used in investigations, credentialling or disciplinary actions (8.08).

Ethics. An important component of quality in the hospital is its ethical behaviour with respect to patients, staff and commercial affairs. The board is responsible for defining the hospital's principles and values, and for ensuring that these are reflected in the hospital's clinical and management activities. The Public Hospitals Act should require each hospital to establish an ethics program as a framework for ethical decision-making. The ethics program should include an ethics enabling statement which speaks to multi-stakeholder management, patient advocacy and ethics training (8.09).

The Patient

Provincial legislative initiatives concerning the rights of the patient are underway. The Steering Committee supports these initiatives which deal with consent to treatment and substitute decisions (9.01). The new Public Hospitals Act should require hospital boards to enact bylaws governing the use of patient restraints (9.03).

Confidentiality and Access to Patient Records. Legislation should protect the privacy of the patient's health records, allow people access to their own health records and health information, and ensure access to such information for quality improvement activities and for research purposes (9.05).

Patient Services Function. The Public Hospitals Act should require all hospitals to establish and maintain an independent Patient Services Function (PSF) with protected funding and safeguards for staff who report objectionable practices in the hospital (9.09). The purpose of the PSF is to provide assistance to those patients seeking changes or adjustments in their treatment or care or in their dealings with hospital staff.

Provincial Responsibilities

The Steering Committee envisions a more active and extensive role for the Ministry of Health with respect to hospitals and, more broadly, with respect to the integration and coordination of health care services.

Balance and Integration. To this end, the Minister should develop planning legislation, complementary to the Public Hospitals Act. This legislation should mandate coordinated and integrated planning at the district, regional and provincial levels, and apply to the public and private sectors of the health care system (10.01).

Funding. The Public Hospitals Act should also provide the Minister and the hospital with more flexibility with respect to funding issues. To assist the hospital to carry out the multi-year responsibilities it will incur under its social contract, the government should take steps to facilitate multi-year fiscal planning by the hospital (10.02).

The Minister should have the formal authority to grant operating funds to hospitals for specified patient programs, research, education and related activities (10.03); and to contract with individual hospitals and intermediate agencies to obtain specific service outputs for regional or provincial programs (10.04).

To balance the hospital's need for flexibility in its capital programs and the Ministry of Health's responsibility for the use of public funds, the Public Hospitals Act should require regulations defining the scope of capital projects which do not need approval by the Ministry (10.05).

Alteration of Services. Inevitably, some hospitals will find it necessary to alter programs and services they have committed to provide under their social contract. The Act should require the Minister to specify the processes to be followed to consider proposals to alter services (10.09).

Inter-Hospital Organizations. The Public Hospitals Act should enable hospitals to merge, combine programs or services, or create new organizations, subject to Ministry approval. The Act should also authorize the Minister of Health, under specified circumstances, to require formation of a joint venture or partnership, a federation with a new board of directors or a merger of hospitals

(10.10). This authority reinforces the fundamental principle that public hospitals are components of a public system of health services, for which the Minister is responsible, to serve the public interest and agenda.

Leadership in Quality. The Minister should consider establishing an institute to provide leadership in education, research and professional development regarding the management and improvement of health care services (10.13).

Investigations. The broad authority of Cabinet to appoint Investigators to report on the quality of a hospital's management, treatment and care should be preserved. The new Public Hospitals Act should be more specific about providing the hospital, except in emergency circumstances, with reasonable access to the findings of the investigation (10.16) and with the opportunity to make representation to Cabinet before the final decision is made (10.17).

Conclusions

The present Public Hospitals Act has served Ontario well over the past 60 years. It is time to develop new legislation to serve society into the 21st century. The legislation should ensure that responsibilities and accountabilities are well defined. The legislation must strike an appropriate balance among the diverse needs the hospital must meet: those of its communities, of the broader health care system and of the Ministry of Health. The overriding goal should be to ensure that at all times the public receives high quality and appropriate services delivered effectively and efficiently.

Summary of Report Recommendations

Chapter 3 - Premises and Principles

(3.01) The Public Hospitals Act should contain the following Declaration of Principles.

1.0 The hospital is a public institution and its primary purpose is to serve the patient.

2.0 Therefore, the purposes of the Act are to ensure that:

2.1 the hospital's services are;

- appropriate to each patient's individual requirements, and
- accessible and provided equitably to its community.

2.2 the hospital recognizes and respects;

- the autonomy of each patient,
- each patient's right to have access to information sufficient to understand and to make informed decisions regarding the available choices for diagnosis, treatment, and care, and
- the dignity and personal, cultural and religious interests of each patient.

2.3 the hospital is responsible and accountable for the quality of the care and services it provides.

2.4 the hospital's structures and processes;

- involve, reflect and respond to the needs of the community,
- facilitate dynamic organizational development,
- foster commitment to organizational goals and objectives, and
- encourage effective intra-organizational relationships.

2.5 the hospital provides an effective, responsive and safe environment.

2.6 the hospital collaborates with other organizations and individuals in its community in the development of a balanced, integrated and accessible system of health services.

3.0 To assist hospitals in carrying out their responsibilities under this legislation, the provincial government should give direction to, and provide for, integrated planning and delivery of balanced and accessible health services.

Chapter 4 - The Social Contract

(4.01) The Public Hospitals Act should require each hospital to develop a social contract.

(4.02) The Ministry of Health should ensure that mechanisms and procedures necessary for the development and operation of social contracts are in place in each district or region.

(4.03) The Ministry of Health should specify in statute or regulation the role of the district health council, or other designated agency, as broker in the process of developing social contracts.

(4.04) The Public Hospitals Act should stipulate that social contracts provide for the education and research activities and affiliation agreements of hospitals.

(4.05) The Ministry of Health should establish a Social Contract Conciliation Panel charged with resolving disputes with regard to social contracts and making recommendations to the Minister of Health on unresolved issues.

Chapter 5 - Governance

(5.01) The Public Hospitals Act should require that each public hospital, (1) be a separately incorporated institution, the incorporation of which is approved by the Lieutenant Governor in Council; (2) be a broadly defined facility which focusses on the diagnosis, treatment and care of illness, disability and trauma on an in-patient and out-patient basis; (3) operate on a charitable, not-for-profit basis; (4) provide members of the public with health services; and (5) function within an integrated health services system.

(5.02) The Public Hospitals Act should stipulate the respective responsibilities of hospital governance and of hospital management.

(5.03) The Public Hospitals Act should specify that governance is the responsibility of the hospital board of directors.

(5.04) The Public Hospitals Act should state that the responsibilities of the board include: defining and ensuring the long-term future of the hospital; defining tne principles, purposes, goals and objectives of the hospital, including its social contract; arranging for and monitoring the effectiveness of the hospital's management; and approving the annual operating plans and budgets of the hospital.

(5.05) The Public Hospitals Act should stipulate that hospital boards are accountable for the quality of hospital services and care.

(5.06) The Public Hospitals Act should require hospital boards to incorporate a commitment to continuous quality improvement in their mission statement.

Governance (continued)

(5.07) The Public Hospitals Act should require hospital boards to establish bylaws to involve all staff and employees in maintaining and continuously improving the quality of patient care and services.

(5.08) The Public Hospitals Act should require each hospital board to establish a Quality of Care sub-committee of the board to make recommendations to the board with respect to quality improvement activities and quality of patient care and services.

(5.09) The Public Hospitals Act should require hospitals to develop an ethics enabling statement.

(5.10) The Public Hospitals Act should require hospitals to establish and maintain an ethics program.

(5.11) The Public Hospitals Act should state that boards of public hospitals are accountable for ensuring that planning and development of programs and services take place, and are coordinated and integrated with, the activities and plans of other providers through provincially-mandated planning processes.

(5.12) The Public Hospitals Act should stipulate that hospital boards be drawn entirely from the communities served by the hospital.

(5.13) The Public Hospitals Act should stipulate that the hospital board must set out in bylaw the criteria and procedures by which persons will be elected or appointed to the board; that these criteria and procedures facilitate board membership which reflects the communities the hospital serves, and provides the skills the board requires; and that the bylaw requires approval by the Ministry of Health.

(5.14) The Public Hospitals Act should stipulate that no person appointed to or employed by a hospital can serve as a member of that hospital's board of directors.

(5.15) The Public Hospitals Act should require that each hospital board establish a formal advisory process to the board; that this process include at least the following advisory councils; Community Advisory Council, Professional Advisory Council, Employee Advisory Council; and that these Councils have the right to communicate directly with the board on all matters related to governance.

(5.16) The Public Hospitals Act should require each hospital board to establish two sub-committees of the Professional Advisory Council; one consisting of regulated health professionals, regardless of their employment status in the hospital, who can admit patients or register outpatients; and one made up of regulated health professionals, regardless of their employment status, who cannot admit or register patients.

(5.17) The Public Hospitals Act should require each hospital board to establish procedures for the election or selection of members to Advisory Councils, for the effective operation of Councils and for their funding.

Governance (continued)

(5.18) The Public Hospitals Act should require meetings of hospital boards be open to the public, except in specified circumstances such as those involving public security, criminal or civil proceedings, personnel matters or property acquisitions.

(5.19) The Public Hospitals Act should require that all hospital bylaws be public documents accessible on request.

(5.20) The Ministry of Health should define in legislation the conditions within which hospital foundations, or other separate corporations of the hospital, can carry out their activities. These conditions should include the following:

(a) the activities of the hospital foundation should be consistent with the approved long range and operating plans of the hospital;
(b) the hospital should not be allowed to transfer funds to its foundation except for bequests, receipted donations or payment for goods or services;
(c) the foundations' transactions with the hospital should be disclosed in the annual audited financial statements;
(d) all hospital foundations should be required to disclose their audited financial statements to the public;
(e) provisions for the disclosure of the corporate records of the hospital should also apply to its foundations; and
(f) hospitals that have raised funds through donations and bequests consistent with approved plans may hold the funds for specific purposes.

Chapter 6 - Management

(6.01) The Public Hospitals Act should stipulate that the primary responsibility of management is the effective and efficient operation of the institution in accordance with the policy directives of the board.

(6.02) The Public Hospitals Act should require that management be responsible for, and report to the board with respect to, compliance with the Public Hospitals Act and Regulations, other relevant acts and the hospital's bylaws.

(6.03) The Public Hospitals Act should require hospitals to develop long-range plans.

(6.04) The Public Hospitals Act should require hospitals to develop their long-range plans in cooperation and consultation with other providers.

(6.05) The Ministry of Health should develop guidelines for cooperative and consultative planning, and for the range of providers to be included in hospital planning.

Management (continued)

(6.06) The Ministry of Health should require hospitals to file their long-range plans with the local district health council, or other provincially-mandated body, and the Ministry of Health.

(6.07) The Public Hospitals Act should require hospitals to develop annual operating plans, taking into account their social contracts.

(6.08) The Public Hospitals Act should require hospitals to file their annual operating plans with their local district health councils, or other provincially-mandated body, and the Ministry of Health.

(6.09) The Ministry of Health should specify the roles of the district health council as mediator and the Ministry of Health as arbitrator in dealing with conflict among hospitals and other health agencies with respect to operating plans.

(6.10) The Ministry of Health should define surplus operating funds taking into account the hospital's need to accumulate funds for future operating losses, program development and capital requirements.

(6.11) The Public Hospitals Act should permit hospitals to use surplus operating funds for capital purposes within the context of approved plans.

(6.12) The Public Hospitals Act should prohibit hospitals from cutting services in order to provide enhancements or additions to their facilities, or to acquire additional equipment, unless the service reductions are part of an approved plan.

(6.13) The Public Hospitals Act should permit, within defined thresholds and without further approval from the Ministry of Health, minor modifications to facilities that do not substantially alter services.

(6.14) The Public Hospitals Act should permit, within defined thresholds and without further approval by the Ministry of Health, financing plans that do not expose the hospital to risk which jeopardizes its continuing financial viability.

(6.15) The Public Hospitals Act should provide the hospital with the flexibility to engage in ancillary activities consistent with the hospital's service objects.

(6.16) The Public Hospitals Act should require management to present regular and comprehensive reports which provide the board with sufficient information to fulfill its responsibilities for the overall effectiveness of the hospital.

(6.17) The Public Hospitals Act should require the board to commission annual audits of the hospital's financial statements and statistical information.

Management (continued)

(6.18) The Public Hospitals Act should require the board to commission periodic independent evaluations of the effectiveness of the organization and its compliance with its social contract.

(6.19) The Public Hospitals Act should require hospitals to establish, by resolution or by-law, an organizational structure that promotes accountability, participation and communication.

(6.20) The Public Hospitals Act should require that the chief executive officer be responsible for, and accountable to, the board for all aspects of hospital management, including utilization of clinical resources and quality of clinical services.

(6.21) The Public Hospitals Act should not define the organizational structure of the hospital below the level of the chief executive officer.

(6.22) The Public Hospitals Act should assign the chief executive officer the responsibility for ensuring that the management structure and processes of the hospital promote accountability, participation and communication with professionals, employees and stakeholders.

(6.23) The Public Hospitals Act should require hospitals to establish, through resolution or bylaw, a process for selection of corporate management officers that promotes participation by stakeholders.

(6.24) The Public Hospitals Act should stipulate that the hospital board is responsible for the appointment of the chief executive officer, and for the appointment of other corporate management, upon the recommendation of the chief executive officer.

(6.25) The Public Hospitals Act should require the hospital board to appoint at least one corporate management officer to be responsible with the chief executive officer for resource utilization and the quality of care provided by individual professionals.

(6.26) The Public Hospitals Act should require hospitals to specify in their by-laws the qualifications of the corporate management officers who will be responsible, with the chief executive officer, for resource utilization and quality of care.

(6.27) The Public Hospitals Act should require hospitals to establish one or more staff committees to advise management with regard to:

- quality improvement;
  - utilization management,
  - clinical records, and
  - quality assurance.
- ethics;
- clinical protocols;
- pharmacy and therapeutics;
- resource allocation; and
- human resource planning.

(6.28) The Public Hospitals Act should require hospitals to establish profession - specific committees to advise management with regard to:

- credentials,
- quality care,
- peer review,
- rules and regulations, and
- discipline.

Chapter 7 - Appointments and Privileges

(7.01) The Public Hospitals Act should provide regulated health professionals not employed by a hospital with the right to apply for access to the hospital's resources appropriate to their scope of practice.

(7.02) The Public Hospitals Act should differentiate among granting access to the hospital's resources for treating outpatients, treating inpatients, registering outpatients and admitting inpatients.

(7.03) The Public Hospitals Act should define the term "appointment" to refer to the statutory and contractual relationship between regulated health professionals not employed by the hospital and the hospital corporation whereby those professionals are granted access to the hospital's resources.

(7.04) The Public Hospitals Act should define the term "privileges" to refer to the specific procedures and therapies which regulated health professionals not employed by the hospital are entitled to perform in the hospital in keeping with their scope of practice.

(7.05) The Public Hospitals Act should prohibit sharing of professional fees with, or payments to, a hospital as a condition of, or in exchange for, an appointment to the hospital staff or specific privileges in the hospital.

(7.06) The Public Hospitals Act should require hospitals to establish bylaws and procedures for credentialling of all regulated health professionals seeking appointment, reappointment or employment.

(7.07) The Public Hospitals Act should stipulate that the board bears ultimate accountability, operationally delegated to management, for appointments and for the delineation of privileges for regulated health professionals.

(7.08) The Public Hospitals Act should require the hospital to develop a clinical human resources plan which defines the types, numbers and scopes of service of the regulated health professionals who will be granted access to the hospital's resources to enable the hospital to meet its commitments under its social contract.

(7.09) The Public Hospitals Act should specify that appointments, reappointments and employment be made within the framework of the hospital's social contract and clinical human resources plan.

(7.10) The Public Hospitals Act should specify the procedures to be used by regulated health professionals, not employed by the hospital, to apply for appointments, reappointments and privileges, and to be used by the hospital in responding to these applications.

(7.11) The Public Hospitals Act should stipulate that management is responsible for suspensions and revocations of appointments and modifications of privileges.

(7.12) The Public Hospitals Act should state that a hospital may decline an initial application for appointment on valid and reasonable human resource grounds.

(7.13) The Public Hospitals Act should allow a hospital to modify or terminate privileges or decline to renew an appointment on valid and reasonable human resource grounds, with reasonable notice.

(7.14) The Public Hospitals Act should stipulate that, with respect to mid-term revocation, suspension or alteration of privileges of a regulated health professional, the privileges in question continue in effect until the appeal process is exhausted, except in two specified circumstances:

(a) the failure of the regulated health professional to comply with specified hospital bylaws or rules; or

(b) there is a question of competence or conduct with clear and compelling risk of harm to patients.

(7.15) The Public Hospitals Act should state that a mid-term revocation, suspension or alteration of privileges related to competence or conduct continues in force pending appeal.

(7.16) The Public Hospitals Act should provide regulated health professionals not employed by the hospital with the right to appeal decisions with respect to their appointments and privileges to a quorum of the hospital board, prior to an appeal to the Hospital Appeal Board.

(7.17) The Public Hospitals Act should provide a regulated health professional not employed by the hospital with the right to a hearing before a quorum of the hospital board where management rejects an application for appointment, reappointment or modification in privileges for reasons other than valid and reasonable human resource grounds, or where the applicant contests whether such grounds are valid and reasonable.

(7.18) The Public Hospitals Act should provide a regulated health professional not employed by the hospital, and subject to a mid-term suspension or alteration of privileges which takes effect immediately, with the right to choose one of the following routes of appeal: a hearing before a quorum of the hospital board followed by an appeal to the Hospital Appeal Board; or an appeal directly to the Hospital Appeal Board without an initial hearing before a quorum of the hospital board.

(7.19) The Hospital Appeal Board should recognize that hospitals involved in teaching or research may include qualifications, experience and performance in education and research, as well as in clinical service, in their criteria for appointments and reappointments.

(7.20) The Public Hospitals Act should expand the mandate of the Hospital Appeal Board to include all regulated health professions.

(7.21) The Public Hospitals Act should expand the size and composition of the Hospital Appeal Board to reflect the range of regulated health professionals with hospital appointments and to provide for a larger pool of members to hear cases.

(7.22) The Public Hospitals Act should stipulate that each panel of the Hospital Appeal Board hearing an appeal by a regulated health professional must include at least one member of the appellant's profession.

(7.23) The Public Hospitals Act should provide for mandatory pre-hearing settlement conferences for appeals to the Hospital Appeal Board.

(7.24) The Public Hospitals Act should provide for the appointment of a Vice-Chair of the Hospital Appeal Board to facilitate pre-hearing settlement conferences.

(7.25) The Public Hospitals Act should require that only one professional is designated as having sole, overall responsibility for any one patient.

Appointments and Privileges (continued)

(7.26) The Ministry of Health should develop mechanisms to facilitate the timely and appropriate exchange of information between hospitals and governing bodies regarding the continuing competence and professional conduct of individual regulated health professionals.

(7.27) The Public Hospitals Act should allow doctrines regarding vicarious liability, and the responsibility of health care institutions for the torts of their non-employee health professionals, to be developed through case law.

Chapter 8 - Quality

(8.01) The Public Hospitals Act should require hospitals to strive continuously to improve the quality and effectiveness of hospital services and care.

(8.02) The Public Hospitals Act should provide for the development of Regulations with respect to:

(a) measures to support quality improvement processes in the hospital;
(b) hospital data to be collected and reported; and
(c) annual reports by the hospital submitted to the Ministry of Health and to the public on quality improvement activities and quality of services and care.

(8.03) The Public Hospitals Act should require hospitals to undergo periodic external review.

(8.04) The Public Hospitals Act should provide for access to patients' health records by hospital staff designated by the board to be responsible for quality improvement, and limit their access to that purpose only.

(8.05) The Public Hospitals Act should make all records and proceedings of a hospital's Quality Improvement Committee, including analyses and reports prepared for the committee and statements made at committee meetings, inadmissible in legal proceedings.

(8.06) The Public Hospitals Act should provide all persons participating in the activities of a hospital's Quality Improvement Committee or Quality of Care Committee with immunity from testifying in court in connection with any aspect of the quality improvement activities of these committees.

(8.07) The Public Hospitals Act should provide all persons participating in the activities of the Quality Improvement Committee or Quality of Care Committee, including committee staff, with protection from liability for actions taken and statements made in good faith in the course of their participation.

(8.08) The Public Hospitals Act should stipulate that proceedings and records of quality improvement activities, undertaken by or for a hospital's Quality Improvement Committee, be treated as confidential information and not used in investigations, credentialling or disciplinary actions.

(8.09) The Public Hospitals Act should require hospitals to establish policies and procedures for dealing with abusive behaviour.

Chapter 9 - The Patient

(9.01) The Government should enact legislation which will:

(a) set out the criteria, requirements and processes with respect to informed consent;

(b) provide safeguards for mentally incapable patients regarding consent to treatment;

(c) establish criteria for legal recognition of advance instructions regarding medical directives, including living wills;

(d) state that patients, including those in long-term and chronic care facilities, must provide informed consent prior to their participation in the teaching or research activities of the institution; and

(e) provide criteria for the development of uniform consent forms written in plain language.

(9.02) The Public Hospitals Act should incorporate those elements of Recommendation 9.01 which are not incorporated in separate legislation.

(9.03) The Public Hospitals Act should:

(a) require hospital boards to establish a bylaw regarding the use of patient restraints; the bylaw should require, at a minimum, documentation in the patient's health record of the use of restraint, the method and administration of restraints used, and patient behaviour leading to the use of restraints; and

(b) define the restraint of a patient to include placing the patient under control when necessary to prevent serious bodily harm to the patient or to another person by the minimal use of such force, mechanical means or chemicals as is reasonable, having regard to the physical and mental condition of the patient.

(9.04) The Ministry of Health should prepare policy guidelines for hospitals on the use of patient restraints.

The Patient (continued)

(9.05) The Minister of Health should enact legislation which:
(a) protects the privacy of the patient's health records;
(b) allows individuals access to their own health records and own health information;
(c) ensures access to health records for quality improvement activities; and
(d) ensures access to health records for research purposes while preserving patient anonymity.

(9.06) The Public Hospitals Act should incorporate those elements of Recommendation 9.05 which are not incorporated in separate legislation.

(9.07) The Government should enact legislation regarding limitation periods for liability which:

(a) establishes a single limitation period of two years from the date of discovery of the injury;
(b) establishes an ultimate limitation period of 30 years after the day on which the act or omission on which the claim is based took place, with a shorter limitation period of 10 years for claims involving negligence of hospitals or hospital employees as well as all negligence or malpractice claims involving health professionals except for claims for "retained objects"; and
(c) continues the current law that limitation periods do not run against minors or incapable persons.

(9.08) The Public Hospitals Act should incorporate those elements of Recommendation 9.07 which are not included in other legislation, as they pertain to hospitals.

(9.09) The Public Hospitals Act should:

(a) set out the responsibilities of the Patient Services Function;
(b) require hospital boards to establish a Patient Services Function;
(c) provide for the independent operation or the Patient Services Function, including a protected funding source; and
(d) ensure protection for staff who complain about objectionable practices in the hospital.

(9.10) Legislation should ensure that persons in public hospitals have access to the proposed provincial advocacy service.

Chapter 10 - Provincial Responsibilities

(10.01) The Ministry of Health should enact legislation which mandates coordinated and integrated planning at the district, regional and provincial levels, and applies to the public and private sectors of the health care system.

(10.02) The Minister of Health should be authorized to contract with individual hospitals and intermediate agencies to obtain specific service outputs for regional or provincial programs.

(10.03) The Government should take steps to facilitate multi-year fiscal planning by hospitals.

(10.04) The Public Hospitals Act should require Regulations to be set which define the scope of capital projects which do not require approval by the Ministry of Health.

(10.05) The Minister of Health should have the authority to grant operating funds to hospitals and other agencies, for specified patient programs, research, education and related activities.

(10.06) The Minister of Health should establish, in consultation with hospitals, a formula which enhances the current approach to allocating provincial funds among hospitals, takes into account service volumes, case mix, changing circumstances in the community and other relevant matters, and is fair and consistent.

(10.07) The Minister of Health should establish regulations setting out the technical grounds on which hospitals can appeal their funding allocations.

(10.08) The Minister of Health should establish time frames for the allocation of funds to hospitals that support sound planning and management processes.

(10.09) The Minister of Health should specify the circumstances and processes to be followed by the Minister and the hospital regarding alteration of hospital services, taking into account the hospital's social contract and the affected parties.

(10.10) The Public Hospitals Act should authorize the Minister, under specified conditions, to require formation of a joint venture or partnership, a federation with a new board of directors or a merger of hospitals.

(10.11) The Minister of Health should consult with hospitals and other stakeholders prior to amendments to, or development of new regulations, except in emergency situations where delay is not in the public interest.

(10.12) The Public Hospitals Act should provide for the development of Regulations concerning the quality of care and service in the hospitals.

(10.13) The Minister of Health should consider establishing an institute to promote, coordinate and provide leadership in education, research and professional development in the management and improvement of health care services.

(10.14) The Public Hospitals Act should provide for the regulation of hospitals by the Minister through review of performance and intervention when necessary to protect the public interest.

Provincial Responsibilities (continued)

(10.15) The Public Hospitals Act should preserve the discretionary authority of Cabinet to appoint Investigators where there are concerns with regard to the quality of governance, management, treatment or care in the hospital.

(10.16) The Public Hospitals Act should require the Minister to provide a copy of the Investigator's report to the chairman of the board of the hospital upon the filing of the report with Cabinet.

(10.17) The Public Hospitals Act should stipulate that hospitals have a right, except in emergency circumstances, to make representations to Cabinet with respect to the report of the Investigator prior to Cabinet decision.

REPORT

CHAPTER 1 INTRODUCTION

Origins of the Review

In 1989, the then minister of health, Elinor Caplan, initiated a comprehensive review of the Public Hospitals Act. The review is one element of the government's broader strategy for redirecting the health system in Ontario to reflect better both our evolving understanding of health and of emerging directions in the delivery of health care services. It is widely recognized in the health sector that the Public Hospitals Act is out of date. The present Act does not provide an adequate legislative framework for hospitals to meet contemporary and changing circumstances in their communities or for their participation in an integrated Ontario health system.

Submissions

The former minister extended an invitation to interested parties to submit proposals for the revision of the Public Hospitals Act. Initially, 27 briefs were submitted by organizations and individuals with an interest in the impact of the Act on hospital organization and management and on the health system.

The Steering Committee

In the fall of 1989, a Steering Committee was formed to consider the submissions and to review the Act. The Committee was comprised of 26 individuals who were selected to bring to the review the perspectives of consumers, health professionals, hospital management and government, and to reflect a broad spectrum of interest in and experience with Ontario hospitals. Once appointed, these individuals functioned as members of the Committee, rather than as representatives of their organizations.

Mandate

The mandate of the Steering Committee was to carry out a comprehensive review of the Public Hospitals Act and advise the Minister of Health on changes and enhancements to the Act which would enable public hospitals to participate effectively in responding to the contemporary and future health needs of Ontarians.

The Process

The Committee drew on:

- the 27 briefs initially received by the Minister;
- additional submissions,
  - 32 briefs received after the Committee initiated its work, and
  - 20 letters regarding the work of the Committee;
- prior reports and studies of the government;[1]
- prior research and reports of relevant organizations in Ontario and other jurisdictions;
- research conducted for the Committee;
- authorities invited to inform and discuss issues with the Committee; and
- expertise and experience of Committee members.

The Committee conducted an extensive review of current and desirable characteristics of the contemporary hospital, the interaction of hospitals with the health system, and the responsiveness of hospitals to the needs of their communities. It also considered governance, management and operating characteristics of public hospitals that would enhance their response to changing circumstances.

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1 These include "Health For All Ontario: Report of the Panel on Health Goals for Ontario", Ontario Health Review Panel, Toronto, August 1987; "Health Promotion Matters in Ontario", A Report of the Minister's Advisory Group on Health Promotion, Toronto, 1987; "Toward a Shared Direction for Health in Ontario: Report of the Ontario Health Review Panel", The Ontario Health Review Panel, Toronto, June 1987; "Report of the Conjoint Review Committee - On the 23 Hospital Operational Reviews", Ministry of Health of Ontario, Toronto, July 1988; and "Toward a Strategic Framework for Optimizing Health: The Premier's Council on Health Strategy, 1987-1991", Government of Ontario, Ontario, March 1991;

Task Groups

The Steering Committee decided early in its deliberations to establish five task groups:

- Governance,
- Utilization and Effectiveness,
- Management Planning and Funding,
- Patients, Residents and Public, and
- Hospital-Professional Relationships.

These task groups conducted the extensive analysis and consideration of these five critical areas and reported to the Committee as a whole. The Governance Task Group was made up entirely of members of the Steering Committee. The Task Groups on Utilization and Effectiveness, Management, Planning and Funding, and Patients, Residents and Public, were expanded to include additional members who brought particular experience and expertise to supplement the perspectives and experience of Steering Committee members. The Hospital-Professional Relationships Task Group named a ten-member "Panel of Experts" to assess and comment on the group's on-going recommendations during the review process.

The Review

The Steering Committee considered the recommendations of the task groups individually and collectively to ensure that they were consistent with the premises and principles that the Committee had established for its work; and to ensure that they would facilitate the desired changes and improvements in such areas as hospital governance, management, delivery of patient care, interaction with other health agencies and providers, and responsiveness to community health needs. The Steering Committee's conclusions reflect an acknowledgement, not so much for changes to individual elements of the current Act, but rather of the need for its redirection and redevelopment.

Although the Committee reached consensus on the need for changes in the Act and on the general direction of those changes, members of the Committee were not always in agreement on each individual recommendation. Each recommendation and its underlying

principles underwent extensive analysis, discussion and debate. In many instances, the Committee directed task groups to reanalyze and reconsider their recommendations. This process subjected recommendations to exhaustive scrutiny. In some cases, as could be expected, differing opinions and perspectives remained among members of the Committee. In the end, where unanimity was not possible, recommendations were formulated to reflect the dominant opinion of the Committee,

The Report

This report is organized into ten chapters. These chapters are interrelated, as are the discussions and related recommendations. They should be considered an integrated whole and not read nor interpreted independently.

Chapter 2 presents the Committee's understanding and perspective on the history of the public hospital in Ontario and the current and future context in which hospitals will function. Chapter 3 presents the premises and principles that guided the Committee's deliberations, and that the Committee recommends should guide both public hospitals in Ontario and the redevelopment of the Public Hospitals Act

The remaining seven chapters of the report present recommendations for redirection of public hospitals and for redevelopment of the Act. Appendices to the report contain a list of the participants in the review (Appendix I) and of organizations and individuals submitting briefs and letters to the Committee (Appendix II).

CHAPTER 2 THE CONTEXT FOR CHANGE

Ontario has changed dramatically since the Public Hospitals Act was first proclaimed in 1931. These changes can be found in the size and diversity of the population, the nature and complexity of health care, the role of the hospital in the community, and the involvement of the provincial government in the funding and direction of the hospital sector.

The Public Hospitals Act and its Regulations were put together over a number of years to accommodate circumstances as they changed. It is not a criticism of the various authors of the Act and its Regulations to note that the result does not reflect a sense of the legislative universe which the contemporary hospital and contemporary circumstances require.

2.1 THE CHANGING FACE OF ONTARIO

There have been enormous changes in the population of Ontario in the past 60 years. As a result of the post-war 'baby boom' and immigration, the population of Ontario has grown from about 3.4 million people to almost ten million today. Ontario, particularly in its cities, is increasingly a multi-ethnic, multicultural society.

Social attitudes regarding public affairs have shifted to a growing emphasis upon openness, accountability and sensitivity to the local, social and cultural needs of a diverse population. Public expectations regarding the professions, public institutions and government have become more demanding, particularly with respect to their accountability to the public, clients and government, where public funds are involved. Health professions and institutions are accepting an increased obligation to listen and respond to the needs and concerns of the patient, community and hospital staff. There are more advocacy groups, activist and lobbyists intent on participating in decisions involving health care, and ensuring a greater degree of responsiveness to their concerns. Conversely, government has been making on-going efforts to respond to these public pressures for openness and responsiveness. One result has been to make more complex the hospital's relations with the communities it serves.

2.2 THE CHANGING NATURE OF HEALTH CARE AND HOSPITALS

Since the 1930's, health services have changed remarkably. There has been a dramatic decrease in the incidence and mortality associated with many diseases. Infectious diseases which typically ravaged populations - tuberculosis, poliomyelitis, smallpox, typhoid - have been either eliminated or reduced to minor phenomena in Ontario. Illnesses which were often fatal - pneumonia, for one - are hardly significant in today's recorded mortality rates. There has also been a remarkable increase in medicine's ability to diagnose, treat, manage and cure disease.

There is no question that much of the improvement in the health of the general population is attributable to such public health measures as clean drinking water, improved nutrition, better working conditions and education. There is also no question that the array of modern diagnostic and therapeutic devices, technologies and medication is critical to maintaining and restoring the health of millions of Canadians. The hospital plays a key role in the organization and delivery of these services.

As medical technology developed during the 1930's and 1940's, it became too sophisticated and expensive for the physician's office. By the 1950's, both physicians and patients were increasingly reliant upon hospitals for access to diagnostic and treatment services. More frequently, the hospital has become increasingly the focus of highly sophisticated secondary and tertiary care, and sometimes even of primary care, for all sectors of the community.

There have been major changes in the types and roles of health professionals. Within the medical profession itself, diagnosis and treatment are increasingly provided by medical specialists and sub-specialists. In earlier years, the regulated health professions included only physicians, dentists and nurses. More recently, new non-medical professions have also developed in specialized aspects of care such as physiotherapy, respiratory therapy, laboratory technology, radiation technology, audiology and clinical dietetics.

2.3 HOSPITAL OPERATIONS AND MANAGEMENT

Hospital buildings may, in some cases, look the same as they did 60 years ago; they may even be the same buildings. What goes on in them today, however, is far more complex and more successful than it was 60 years ago.

For many years, the hospital was primarily an extension of the practice of the physician. The hospital's Superintendent, subsequently Administrator, was often a physician. Physicians, who were mostly independent practitioners dependent upon the hospital for their professional practice and livelihood, reported directly to the board and sat as member of the hospital board. The focus of hospital administration was providing the resources to support the work of the physician. The hospital developed a bifurcated system of administration cum management, with both the administrator and the chief of staff of medicine separately reporting and responsible to the hospital board of directors; an arrangement which received legislative force in the current Act. In many hospitals working under this bifurcated arrangement, the distinctions among hospital governance, management and administration have often not been clear, and areas of responsibility and lines of accountability have often not been well defined.

Over the years, the hospital began to broaden its perspective. It began to take on the dimensions of a public institution with a growing responsiveness to the broader health issues in the community as well as to the increasingly complex needs of patients admitted by physicians. The scale, complexity and diversity of the hospital's operations have required it to pay more attention to the broader issues of management, of which administration is one part. These issues include organizational development, strategic and operational planning, budgeting and finance, utilization of resources and effectiveness of services. These activities, necessary in all organizations, are increasingly recognized as key factors in ensuring the hospital is governed and managed to deliver the necessary services to its community.

The hospital's reporting responsibilities and accountabilities have become more rigorous; data bases and information systems more extensive and sophisticated.

Nowhere are these changes more apparent than in the hospital's requirements for assembling, organizing and managing the human, physical and financial resources necessary to provide clinical services.

2.4 THE PROVINCE AND FUNDING

Over the years, the roles and responsibilities of the provincial government in the hospital sector have expanded in part, because of the growth in provincial funding since the 1950's. This has led, among other things, to a greater emphasis upon a province-wide approach to coordinating and integrating health programs and services.

2.4.1 Funding the Hospital

The cost of operating a hospital has increased steadily, particularly in the past 20 years. The content of treatment has changed dramatically and we are now paying for a vastly different and more effective set of services than previously, and for the specialized staff associated with those services.

Until 1957, both public and private hospitals charged patients for their services. Patients paid directly, or through a private hospital insurance program or were treated on a charitable basis. The cost of caring for indigent persons was paid for by the local municipality. Additional funds for the care and treatment of the poor were provided by the province and through private fund raising.

The introduction of provincial government funding for hospital operations and capital programs brought a degree of financial stability to hospitals undergoing rapid expansion and technological changes. Provincial funding also increased the hospital's dependence on the provincial government. The hospital, once a privately funded institution, has become what amounts to a public service or utility paid for largely from public funds. The public holds the provincial government responsible for the funding, organization, delivery and, to some extent, the quality of hospital services - at least to the point of ensuring that adequate treatments and technologies are available and accessible.

The extent of the provincial funding responsibility for hospitals - most of the operating costs plus the greater proportion of capital costs - and every government's need to ration limited resources, has brought the province more directly into issues of health systems management. Increasingly, the Ministry of Health stresses effectiveness, efficiency and improved reporting with respect to the expenditure of public funds. This emphasis extends beyond short-term considerations of government deficits and revenues (although these are important concerns). The issues pertain more broadly and fundamentally to accountability by the hospital to the government and public for its use of public funds, and for the long-term financial viability and effectiveness of the hospital sector as it moves into the 21st century.

2.4.2 The Provincial Health Care System

Public expectations of the health care sector, including hospitals, are rooted in the five principles of the health insurance program introduced 30 years ago. These principles, embodied in the Canada Health Act, can be summarized as:

- Universal: all Canadians are entitled to health insurance;
- Accessible: all Canadians are entitled to health services without financial or other barriers;
- Portable: a Canadian can obtain health service in any province without charge;
- Comprehensive: all Canadians have health insurance which covers a comprehensive range of medically necessary health care services; and
- Public Administration: health insurance administered by a public agency on a not-for-profit basis.

Discussions on health care in Ontario often refer to the "health care system". The phrase is convenient but potentially misleading. Historically, health services in Ontario have been provided by individuals and agencies, including hospitals. They have operated more or less independently of each other, but have cooperated through interlocking and overlapping sets of formal and informal arrangements.

Although Ontario's health care system is one of the finest in the world, it tends to be de facto and informal rather than formal. Ontario hospitals have proven themselves over the years to be remarkably effective, safe, resilient and responsive to changing circumstances. In the past years, however, continuing changes in health care, the range of jurisdictions involved, the scale of health services, costs and provincial budget limitations have created more complex and interdependent conditions which necessitate a more formal and systematic approach to the coordination and integration of resources and services.

The situation is not unique to Ontario. Health services in all jurisdictions, whether privately or publicly funded, face similar pressures, and the need to rethink their organization and delivery of health programs and services. Increasingly, the public demands accountability for the operation of health services, both for services delivered to the individual and for services at the system level, and for equitable access to appropriate programs and services for all members of the community within available resources. Accountability, in turn, requires that the roles and responsibilities of each element of the health system and their relationships to each other be set out clearly and specifically.

Over the past years, there has been a trend towards rationalization of hospital services across the province. Sometimes, rationalization has taken the form of voluntary transfers of programs from one hospital to another; in other instances there have been mergers and acquisitions among hospitals; and, in other cases, consolidation of programs. These changes have been carried out largely on an ad hoc basis.

The hospital's arrangements with other hospitals and health care providers in the community, and in the district and region, however, are still often fragmented, inadequately organized, and imperfectly understood. What is missing is a comprehensive framework within which each hospital can plan, coordinate and deliver services so as to ensure, at the local, district and provincial levels, the most effective and efficient use of resources to meet the needs of the patient and the community.

The provincial government in recent years has taken steps, this review being one, to establish a more formal and accountable system of health services and facilities across the province; for example, through the establishment some 10 years ago of intermediary planning and coordination agencies such as district health councils. When such a system is in place, the provincial government will be in a better position to ensure to the public that it has exercised wisely its responsibilities for health services and for the expenditures of public funds.

The objectives of the health care system towards which the government is moving are not limited to treatment services, but pertain more broadly to support healthy communities. This is manifested in a shift towards a community-based, multidisciplinary system-based approach to services, health promotion and illness prevention. Stakeholders in such a health care system include not only hospitals and regulated health professionals, but all those who contribute to public well being and health promotion. These include community health services and also housing, social support and volunteer efforts. The values of such a system include a focus on the well-being of the patient or client, inter-service cooperation, collaboration, integration and the coordinated use of resources.

The provincial government, however, does not possess the legislative means necessary to achieve its objectives. In the hospital sector, with which this review is concerned, there is a need to create a greater degree of legislated consistency and coordination. The roles and responsibilities of the individual hospital have to be redefined with respect to the community, the health care system and the provincial government. Each hospital needs to understand what is expected of it in the kind of health care system the provincial government is working towards, and the ways in which it will be expected to fulfill its responsibilities.

A Public Hospitals Act is unlikely to meet all these requirements. Over the past years, the provincial government has brought forward a number of initiatives to support the move towards a better coordinated and integrated health care system. The review of the Public Hospitals Act needs to acknowledge these efforts.

2.4.3 Regulation

The traditional responsibility of the province has been to regulate hospitals. With that responsibility comes the legislated authority to inspect, to investigate, to supervise, and if necessary in extreme situations, to appoint a supervisor to act on behalf of the hospital's board of directors. These powers need to be retained in the public interest. There is also a need to consider how these responsibilities can be effected to ensure fairness to all concerned.

2.5 LAYING THE FOUNDATIONS

As we enter the last decade of the century, amidst changes in health care which could not be imagined 60 years ago, it is appropriate to examine the legislative basis of the hospital for the coming decades. We need to set out the principles and goals and to lay the foundations for a comprehensive, enabling, consistent yet flexible approach to hospitals which will take us into the 21st century. In this task we need to look back to what should be preserved and protected, as well as forward to what should be changed.

CHAPTER 3 PREMISES AND PRINCIPLES

3.1 INTRODUCTION

The public hospital sector, as part of the Ontario health care sector, is characterized by a diversity of legitimate and necessary interests. These reflect the different values, pressures and needs which must be accommodated and balanced in each hospital and in the health care sector as a whole:

- the hospital's need to use resources for the individual patient and the needs of the community;
- the hospital's need to use resources now and the need to maintain resources for future requirements;
- the need of the provincial government to ensure an integrated health system and the appropriate use of public funds and the individual hospital's need to respond to changing local circumstances;
- the values and culture of the individual hospital and the wider public agenda;
- established hospital practices and new technical and managerial developments;
- the hospital as a physical facility and the changing focus to community health care;
- the hospital as a locus for treating the very sick; and
- the hospital as a community resource for wellness.

The Steering Committee, after considerable discussion, came to broad agreement on basic premises which would direct their work, on the issues to be addressed, the direction in which change should take place and the principles upon which changes in the Public Hospitals Act should be based. Although there was not always full agreement on every conclusion and recommendation, this general agreement on premises and principles held throughout the Committee's deliberations.

3.2 BASIC PREMISES

The basic premises that underlie the Committee's perception of the direction of change needed in the Public Hospitals Act, and the reasons for change, can be categorized as (1) enabling legislation, and (2) the coordination and integration of health services

3.2.1 Enabling Legislation

As the Steering Committee went about its deliberations, the most common question it faced, in one form or another, was: what is the purpose of legislation? Legislation should not hinder but enable the hospital to fulfill its responsibilities. Conditions and needs across the province vary greatly. Hospitals themselves vary widely in their scope and scale of resources, programs and services. It would be impossible to attempt to develop prescriptive legislation which could foresee and cope with all these variations.

The role of the legislation, therefore, should be to enable and encourage the hospital to work with the community or communities it serves, and its stakeholders, to develop the range, mix and organization of programs and services most appropriate for that community. The legislation should serve to foster the latitude, ability and creativity of each hospital to meet the current needs of its patients and its communities, and to plan for and address the changing circumstances the future always brings.

We advocate a legislative approach which sets out the principles and goals to which all hospitals must subscribe, for example with respect to quality, patient rights, governance, management and accountability, and the framework and processes within which these are to be accomplished. Each hospital would have the freedom and responsibility within that legislative framework to fulfill these requirements in the ways it considers most appropriate.

The premise of enabling legislation does not disguise the reality that the very existence of legislation is, in itself, prescriptive. The prescriptive components of the legislation

should be directed to ensuring the Minister can fulfill her responsibilities, for example with respect to the health care system, accountability and public safety, and to ensuring that the hospitals understand and meet theirs.

From a practical perspective, however, the Ministry of Health has been moving in the direction of a non-prescriptive approach. The current position of the Ministry is that, once it has agreed with a public hospital on the hospital's general program it tends to remains at arms length from the hospital's day-to-day activities unless and until a major issue emerges. At that point, the Ministry intervenes as it deems appropriate.

There is a need to provide the legislative and regulatory framework for this enabling arrangement. The public interest requires that hospitals operate within more comprehensive and clearly defined standards of responsibility and accountability than the current Act provides. Within the framework of these standards, however, hospitals should have the latitude and opportunity to respond as best they can to the needs of their communities.

3.2.2 Coordination and Integration of Health Services

The key links to coordinating and integrating health services - i.e., creating a "system" - include the Ministry of Health, and its agencies such as district health councils, and hospitals and other providers working through planning processes that include the community and the patient. It is important in the review of the Public Hospitals Act to differentiate among the roles of these major stakeholders.

The Ministry of Health. The Ministry of Health, through the Ministry of Health Act, has a number of legislated responsibilities. These include:

- the development, coordination and maintenance of comprehensive health services and a balanced and integrated system of hospitals, extended care facilities, nursing homes, laboratories, ambulances and other health facilities;

- payment of a defined share of the hospital's operating and capital expenditures;
- the care, treatment and services and facilities provided by hospitals and health facilities, and to assess the revenues required to provide such care, treatment and services;
- controlling charges made to all patients in hospitals and health facilities; and
- inquiring into and determining the hospital and health facilities, services and personnel required to meet the health needs of the people of Ontario.

As well, the current Public Hospitals Act gives the Minister of Health specific responsibilities for the organization and operation of individual hospitals, but not for the delivery of individual public hospital services.

In response to changing circumstances and its legislated responsibilities, the Ministry has been developing a more formally organized and coordinated system of health services based on a province-wide approach to service planning, organization and delivery. This approach emphasizes, among other things, the effective management of public resources at the levels of the individual provider and of the wider system.

The Ministry of Health has also adopted more of a strategic perspective in the execution of its several responsibilities. It has directed more effort towards establishing goals and objectives for the health care system as a whole, including the hospital sector, and developing the mechanisms for implementation of strategies to achieve them.

The Steering Committee accepts as a basic premise that the Ministry will, and should, continue in this direction. Consequently, the Public Hospitals Act must not only acknowledge the regulatory responsibilities of the Minister of Health, but should also accommodate and support this strategic approach to the planning, coordination and delivery of health services.

District Health Councils. District health councils, and other provincially-mandated planning bodies, will play an increasingly important role in this strategic approach. Originally established by the provincial government to provide it with advice on the needs of the individual health districts or regions, each council includes representation from a cross section of interests, including the providers, consumers, the communities within the district or region and elected officials. The councils are not responsible for the direct delivery or management of health services. Their responsibilities include facilitating community input into the identification of needs and plans, and, on behalf of the government, facilitating the development of a planned and integrated system of services within each council's area of jurisdiction.

District health councils should continue to play an important role in the planning and coordination of local services. It is in the public interest that the individual hospital plan and deliver its programs and services within the planning and coordination framework established by the district health council. The Public Hospitals Act, therefore, should specify the relationship of the hospital to its district health council or councils, the responsibilities of the hospital to its council, and the processes through which the respective responsibilities of each are effected.

The Hospital. The Ministry of Health and the district health councils are responsible for determining and ensuring a planned and coordinated system of health care. The hospital's responsibilities are to manage and deliver its mandated services in the most effective and efficient manner it can, to optimize the resources available to it and to strive continuously to improve the availability and quality of its services. The hospital defines its mandate within the framework established by the Ministry of Health and through the district health councils.

Hospitals also have an independent advocacy role. The hospital is a legitimate representative of interests of clients, providers of services and the community. It is also a highly skilled resource for the provision of improved services. These roles, however, do not detract from the hospital's primary responsibilities for managing and delivering its services.

The Community. The public hospital acts in a partnership with its community or communities. It provides the members of the community with programs and services, and in turn is supported by the community through the work of volunteers on the board, board committees and in the daily activities of the hospital, through the community's fund raising efforts on behalf of the hospital and in other ways. The hospital is in essence a community organization.

Within its community, the hospital works in collaboration with other hospitals, health professionals, other health-related agencies, volunteer groups and a range of social and other services, including the district health council. The current Public Hospitals Act, however, does not address issues around the hospital's relationships with its community or communities, or with the other providers in the community.

The Patient. The patient is the fundamental reason for the hospital's existence in the community and is the primary focus of its programs and services. The patient is the essential link in the development of a coordinated, integrated and balanced system of health services.

In recent years, there has been a growing emphasis upon what is sometimes described as the empowerment of the individual vis-a-vis the institutions of society. These changes have been reflected in the hospital sector. Many hospitals are making greater efforts to ensure that the patient is well informed about the health service the patient is to receive and about the alternatives, and to include the patient in the decision-making around treatment and care. Hospitals have also attempted to include the family of the patient as part of patient support. These developments, which are consistent with the direction in which the Ministry of Health has been moving for some years, are not reflected in the current Public Hospitals Act.

The Role of the Public Hospitals Act. The Public Hospitals Act should be an important instrument for facilitating and strengthening the Ministry of Health's strategic thrust to a coordinated, integrated and balanced system of health services and facilities. The Act should define the levels of need to which the hospital must respond: patient, community, district and provincial. The Act should specify the roles and responsibilities of the stakeholders at each of these several levels, and provide the framework within which programs and services can be planned and delivered, and coordination and integration can take place.

By so doing, the Act should also provide one of the necessary legislative bases for defining the accountability of each of the participants in the health care sector, including the hospital. The public has a powerful interest in ensuring that the health care sector provides effective services, is efficient in the use of public resources and is accountable for its decisions. Accountability is an important component of the Ministry's province-wide approach to coordination and integration of health services. In this approach, the principle of accountability should extend throughout the entire health care sector: from the accountability of the government to the public for the expenditure of public funds; to the accountability of the individual hospital to each of its patients for the quality, appropriateness and effectiveness of the hospital's health services.

3.3 PRINCIPLES

Within the context of these working premises, the Steering Committee developed six principles upon which it has based its specific recommendations. These principles pertain to the governance, management and operations of hospitals, and how hospitals should relate to their patients, community, staff, other health providers and the provincial government. Each principle is fundamental within its own sphere, and dependent for its effectiveness upon the other principles. The principles can be summarized as:

- accessible and equitable patient-centered treatment and care;
- responsiveness to community, regional and provincial needs;
- accountability to the patient and public;
- commitment to quality;
- management effectiveness; and
- respect for the values and traditions of the individual hospital.

The tensions and potential conflicts among these principles are characteristic of the issues which all health care services, public and private, must face and resolve.

3.3.1 Accessible and Equitable Patient-Centred Treatment and Care

The primary purpose of the hospital is to serve the patient so as to achieve the best available outcome. A hospital may have other purposes such as education, research or health promotion. But, its first responsibility and focus is the patient.

Access. All hospital services insured under the Ontario Health Insurance Act should be available and accessible to all insured persons on an equitable basis. There are practical difficulties in achieving availability, for example in thinly populated areas such as Northern Ontario. Often, hospital services must be located in larger centres to achieve economies of scale; specialized professionals, technicians, equipment and facilities require a large population base in order to function efficiently and cost

effectively. The location of a hospital, no matter where, inevitably creates difficulties of access for those who do not live within a convenient distance. A Public Hospitals Act cannot ensure that hospital facilities and services are available everywhere in the province. All the more reason for the Act to stress the importance of access and equity.

Patient Rights. The principle of patient-centered treatment and care requires that the hospital respect the autonomy and dignity of the patient. The patient has the right to be included in discussions and decisions on diagnosis, treatment and care, and the right to the information necessary in order to participate usefully in those discussions and decisions. Many hospitals have already taken this position. It is important, however, to ensure that the legislation specifies these entitlements and the hospital's responsibilities in this regard.

3.3.2 Responsiveness to Community, Regional and Provincial Needs

Hospitals must be responsive to the broader public needs, interests and agendas. There are two perspectives from which responsiveness can be addressed.

Community Interests. Responsiveness on the part of the hospital to its communities requires that the hospital board of directors, through its own membership and that of its various committees, reflects the composition and interests of the various communities served by the hospital. Responsiveness also requires that the board establish a variety of mechanisms through which the hospital can reach out to and include in its deliberations a broad cross-section of the interests of its communities. This cross-section might include community groups, other providers, special interests, and persons with special qualifications. By seeking advice and information from these people, the hospital is better able to identify and more likely to respond appropriately to community needs. The Public Hospitals Act should provide the enabling means and framework through which hospitals can effect this responsiveness.

Community Needs. Over the years, the hospital has acted in response to the needs of its stakeholders and communities. Community needs might be defined at the district or regional level by the district health council or a regional planning body; in many cases, the hospital relates to several district health councils because of the distribution of its various communities. Often, other local health care providers and stakeholders are involved in meeting these needs. The hospital also has a wider responsibility to respond to the provincial interests and agenda.

The Public Hospitals Act needs to address in a systematic way the manner in which the hospital should respond to various levels of needs. The roles and responsibilities of the hospital, the community and district agencies and the Ministry of Health should be specified and defined. Procedures and mechanisms through which the hospital will respond, and through which these stakeholders interact with each other, should be established, along with the accountabilities of each.

3.3.3 Accountability to the Patient and to the Public

Accountability is the necessary foundation for a responsive and responsible health care and hospital system. There are two levels of accountability which need to be addressed. The first is within the hospital itself. As a patient-centered institution, the hospital should be accountable, within the context of established legal doctrine, first to the patient for the appropriateness, safety, quality and effectiveness of the services provided to that patient. This should be supported by an internal system of accountability to the board. This accountability is essential to effective governance and management.

A second level of hospital accountability is to the community and, on behalf of the broader public, the Ministry of Health. The hospital should be held accountable to the public for using its resources effectively and efficiently, for fulfilling, within the limits of its resources, its commitments and responsibilities, and for managing its resources to ensure its long-term viability and ability to handle future demand.

Accountability, to be successful, requires vehicles such as openness, public proceedings, public access to records and specified reporting procedures. Apart from the appropriate and necessary restrictions on public access to confidential patient and staff records, the hospital should be held accountable for conducting its affairs in public. The public can then determine how the hospital has conducted its affairs and fulfilled its responsibilities.

3.3.4 Commitment to Quality

The principle of quality embodies three central objectives of everyday hospital life. One is that the diagnosis, treatment and care the patient receives is appropriate and effective. Another is that hospital services meet or exceed generally accepted standards of quality. The third objective is that the hospital be a safe place for the patient and those working there; people should not get sick or injured from being in a hospital.

These objectives which embody the principle of quality are not separable. A total organizational commitment to quality is required throughout all dimensions and parts of hospital activity. The primary focus is on the patient and directed towards the continuity and quality of diagnosis, treatment and care. The process begins by embedding the commitment to quality in the philosophy, values and mission of the hospital. This commitment requires dedicated leadership and the complete support of all hospital staff. Objectives need to be set, reviewed, revised and upgraded on a regular basis. The operational aspects of the commitment to quality require strategic, operating and financial planning to achieve specified objectives. Comprehensive systems, organizational relations, integration and coordination, are required to ensure implementation, and for the generation of performance data for the on-going monitoring and evaluation of all aspects of the hospital's activities from the perspective of the commitment to quality.

This approach views quality much more broadly than traditionally has been the case. It shifts the focus from the performance of individual practitioners to that of organized teams of care givers, to the performance of the hospital and, ultimately, to that of the

entire health care system. Quality, therefore, must address not only clinical and professional aspects of care such as effectiveness, efficacy and appropriateness; it must also address social issues such as accessibility, continuity of care, confidentiality, participation of the patient and family in care; and administrative aspects of care giving such as timeliness of care, efficiency of care, safety of the environment and support to caregiving.

In this approach to quality of care, efforts at improving quality do not stop at uncovering poor quality after the fact, or even of preventing poor quality and ensuring performance to generally accepted standards. This approach calls for continuous improvement in quality throughout the hospital by everyone involved in the hospital, no matter what the existing level of performance. Underlying the principle of continuous quality improvement is the intention to obtain the best quality and most value out of the hospital and the health care system for the patient and for the public.

3.3.5 Management Effectiveness

The current Public Hospitals Act speaks to the administration of hospitals and the responsibilities of the hospital administration. The Act, however, has little to say about the broader issues of the management of the hospital and of its resources, programs and services.

The Public Hospitals Act should establish the authority of management to manage; define the respective roles and responsibilities of governance and management; specify the responsibilities and accountabilities of management; and provide management with the flexibility to develop structures most appropriate to fulfill its responsibilities.

Hospitals are extraordinarily complex organizations which work in changing, and sometimes volatile, unexpected circumstances. A hospital requires a vigorous, well-managed organization with the flexibility to establish and maintain its commitment to quality improvement and to meet its many and diverse responsibilities to the patient, the community and the province. There can be disagreement about what the term "healthy

organization" means. There is agreement, however, that a healthy organization, at a minimum, is managed and staffed by qualified and competent persons who are committed to the philosophy and values of the hospital, and work hard in cooperation and collaboration with each other towards the fulfillment of commonly accepted goals and objectives.

3.3.6 Values and Traditions

Hospitals are community institutions. Every hospital, even the largest and most sophisticated, grew out of and is rooted in a unique set of circumstances. These create and shape the values, culture and traditions of the hospital, its staff and volunteers, the way the hospital reaches out and responds to its communities. These values and traditions are at the core of hospital life.

As the communities grow and change, so does the hospital. As the hospital reviews and reshapes its programs and services to meet these changes, it redefines its values and traditions and its relationship with its communities. The Public Hospitals Act needs to acknowledge this relationship, and provide support for the history, traditions and values of the individual institution, as well as for its obligations to meet changing circumstances.

3.4 A NEW PUBLIC HOSPITALS ACT

The current Public Hospitals Act does not reflect the breadth and vision of the premises and principles outlined above. A new Public Hospitals Act is needed which begins with these premises and principles as its foundation. Such an Act should support and complement the other legislative initiatives which are part of the Ministry of Health's strategic approach to health, health services and facilities.

3.4.1 A Declaration of Principles

The principles set out in this chapter should guide the interpretation of this report, and the development and interpretation of a new, invigorated and more effective Public Hospitals Act.

Recommendation

We recommend that:

(3.01) **The Public Hospitals Act should contain the following Declaration of Principles.**

1.0 The hospital is a public institution and its primary purpose is to serve the patient.

2.0 Therefore, the purposes of the Act are to ensure that:

2.1 the hospital's services are;

- **appropriate to each patient's individual requirements, and**
- **accessible and provided equitably to its community.**

2.2 the hospital recognizes and respects;

- **the autonomy of each patient,**
- **each patient's right to have access to information sufficient to understand and to make informed decisions regarding the available choices for diagnosis, treatment, and care, and**
- **the dignity and personal, cultural and religious interests of each patient.**

2.3 the hospital is responsible and accountable for the quality of the care and services it provides.

2.4 the hospital's structures and processes;

- **involve, reflect and respond to the needs of the community,**
- **facilitate dynamic organizational development,**
- **foster commitment to organizational goals and objectives, and**
- **encourage effective intra-organizational relationships.**

2.5 the hospital provides an effective, responsive and safe environment.

2.6 the hospital collaborates with other organizations and individuals in its community in the development of a balanced, integrated and accessible system of health services.

3.0 To assist hospitals in carrying out their responsibilities under this legislation, the provincial government should give direction to, and provide for, integrated planning and delivery of balanced and accessible health services.

CHAPTER 4 THE SOCIAL CONTRACT

4.1 INTRODUCTION

The public hospital sits in the midst of an informal system of agencies and individuals providing services to the community. This informal arrangement leaves some services fragmented, uncoordinated or absent, and allows other services to be duplicated unnecessarily or to change suddenly, because of unforeseen circumstances, without notice to other providers or the public .

From the perspective of both the public and the government, the informality of the system diminishes responsibilities and accountability. The community needs to know what to expect from whom, and what the responsibilities and accountabilities are of the various participants. The government has an obligation to ensure that public funding of hospitals and other health agencies is coordinated in a way that serves the community effectively and efficiently.

Coordination requires that the hospital (and other health agencies) plan within the context of the overall health needs of the community. This type of contextual planning requires the identification of needs and the development of a comprehensive plan for responding to these needs. A major step toward the development of such plans has been the establishment of district health councils. Councils can facilitate planning by identifying community health needs and coordinating plans and services among health agencies, including the hospital.

What is required is an agreement between the hospital and its community regarding the role it will assume in responding to community health needs. These agreements could be facilitated by the district health council to ensure that needs are responded to as comprehensively, effectively and efficiently as possible. Such an agreement might be called a "community services agreement', "hospital services agreement", "service framework agreement" or "community contract". We have chosen to call it the "social contract".

4.2 DEFINITION OF THE SOCIAL CONTRACT

4.2.1 Purpose of the Social Contract

Because of the hospital's importance as the largest single provider of health care services in the community, the social contract between it and its community would be a cornerstone of health planning and service delivery in the community. The social contract would set out the understanding of both the hospital and the community about the role and responsibilities of the hospital in the community, the services it will provide and how these fit in with those the other hospitals and agencies are expected to provide. The hospital's objectives and long-range plan would be made consistent with, and incorporated into, the negotiated agreement. Both the community and the Ministry would thus have a clear understanding of programs and services for which the hospital was responsible.

4.2.2 Conditions of the Social Contract

All hospitals in the province should be required to develop a social contract. The contract should be negotiated within the planning framework established by the district health council and the Ministry of Health. The contract would be based on a negotiated agreement between the hospital and its public on the health service needs to be addressed by the hospital within the planning framework. The hospital's undertaking would be to provide those services it was best equipped to provide, within the reasonable limits of available resources, according to priorities established with its community.

The word "contract" is not meant to suggest that the social contract is a legally binding document which can be enforced by legal action. Rather, the social contract is an undertaking by the hospital and its community made in good faith to use their best efforts to meet specified commitments under an anticipated set of circumstances. The

social contract is subject to the understanding that it may require renegotiation if circumstances change. To allow for such changes, the social contract should contain procedures through which the hospital and the community can revise the contract as required.

The concept of the social contract is an extension and formalization of the kinds of informal arrangements which already exist in many communities between the hospital and other hospitals and health agencies. The contract would resemble the Role Statement most hospitals in Ontario already develop. The social contract would also provides a process for interaction and negotiation between the hospital and its community to articulate each party's expectations of the other, assign roles and responsibilities, coordinate resources and establish accountabilities.

4.2.3 Parties to the Contract

At the very least, the social contract must contain an understanding between two parties. On one side is the public hospital and on the other side is the public. It is clear that the board will enter into the 'contract' on behalf of the hospital. Who, however, is the community?

The complexity of the contemporary hospital in Ontario extends to its community. Many hospitals serve different communities. The most common characteristic of a hospital community is its proximity to the hospital. Other communities of the hospital might be defined by the functions, programs or services they receive from the hospital. These "functional communities" might be defined by age, gender, ethnicity, language, type of care required, type of chronic disease or condition, predisposition or susceptibility to a specific disease, or participation in clinical education or research. In developing its social contract, the hospital should reach an understanding with each of its functional communities regarding its role in responding to their needs. Taken together, these functional communities form the 'composite community' of the hospital.

In addition to its functional communities, a hospital's social contract should take into account the interests, programs and services of other agencies responding to the needs of these communities. The social contract should describe the relationship among the hospital, other agencies and the functional community. As a result, these other agencies should participate in and be considered third parties affected by a hospital's social contract. The third parties which might be affected by a hospital's social contract with its composite community include:

- other hospitals in the community,
- referral centres providing secondary, tertiary or quartenary care,
- long-term care facilities,
- home care agencies,
- hospices,
- ambulance services,
- health service organizations and community health centres,
- free-standing clinics,
- public health units,
- social service agencies, and
- academic institutions.

4.2.4 Negotiating a Social Contract

There are a number of ways for a hospital and the other parties to arrive at a social contract. No one process will likely be applicable throughout the province for all hospitals or for all districts. There is a public interest, however, in ensuring that the process for developing the social contract meets at least minimum requirements. For example, the process should:

- take into account the health needs of the hospital's functional communities;
- involve the public as a primary participant;
- provide for consultation with other potentially affected health agencies;

- ensure all relevant issues are addressed and resolved; and
- accommodate local conditions and at the same time ensure province-wide consistency with respect to content.

Likely, responsibility for initiating work on the social contract would rest with the hospital. The board and senior management would work with advisory councils and staff to prepare initial statements of the hospital's objectives and long-range plans. These would provide the basis for the development of a first draft of the social contract which would be the starting point for discussions with the other parties to the contract.

The district health council (or other provincially mandated body) would play a pivotal role as the broker in the development of the hospital's social contract. The council's roles would include facilitation, conciliation and mediation. It would oversee the development of the contract, ensuring that the appropriate functional communities, interested organizations and affected agencies were identified and involved in the discussions. The process would include wide consultation with members of the public and affected organizations through community advisory councils, municipal councils and mechanisms such as community forums, focus groups and surveys.

The district health council would ensure that the social contract discussions were appropriate to the requirements of the district, area, or region, and that pertinent data, documentation, reports and other information were available. The council would strive to ensure that the relevant issues were resolved satisfactorily in the contract. If conflicts were to develop, the district health council would strive for reconciliation of the divergent positions within the context of district needs.

A critical input to these discussions will be the parties' assessment of the adequacy and appropriateness of the current response by the hospital and other providers to the health service needs of the composite community. This assessment should include:

- health status of the community;
- needs of the community for
  - illness prevention,
  - health promotion, and
  - delivery of services;
- resources available to the community including
  - clinical human resources,
  - technologies,
  - facilities, and
  - financial resources;
- current health services;
- overlapping services and redundant resources; and
- gaps in services and resources.

The focus of the discussions should be the role of the hospital in responding to the health needs of the community, taking into account the resources available to the community and the hospital, and the appropriate relationship of the hospital's services to those of the other health agencies. The hospital's role should be determined by the relative efficacy and efficiency of services which the hospital can provide compared to other hospitals and agencies.

The nature of the social contract requires that it be part of a larger whole. To be effective, the social contract must be part of a web of other social contracts between other hospitals, and their composite communities, and of other health agencies. The district health council should be responsible for ensuring that the negotiation process for each contract considers the overall needs of the community in relation to the other social contracts and services of the other agencies. The goal should be to ensure that health needs in the district or region are met effectively and efficiently by a coordinated network of health services.

When an appropriate agreement has been achieved, the social contract should be signed by the hospital and by the Ministry of Health on behalf of the hospital's composite community. The Ministry would sign on the recommendation of the district health council that the relevant issues had been addressed, that there was a good fit between needs and resources, that meaningful negotiation had taken place with all the functional communities, that the appropriate organizations had been consulted and that a reasonable accommodation had been reached among all the parties. If the district health council could not broker an agreement, and the differences between the parties were deemed to be intractable, then the council would recommend that the Minister refer the social contract to a process to be established for the resolution of such differences.

4.2.5 Scope and Content of the Social Contract

The content of a hospital's social contract will vary in scope and complexity depending upon the functional communities to be served, the health needs to be addressed, the complexity of the hospital's role, the proposed relationship with other health agencies and the nature of proposals for changes to the hospital's existing role and responsibilities.

Notwithstanding the variety of social contracts which may be developed, there is a public interest in ensuring that all contracts contain such information as:

- the parties to the agreement;
- description of the characteristics of the hospital at the start of negotiation for the current version of the social contract, including;
  - ownership,
  - inpatient programs and program volume,
  - outpatient programs and program volume,
  - diagnostic and therapeutic services,
  - clinical human resources,

- facilities, and
- financial resources;

- description of the functional communities to be served;
- identification and description of third parties including;
  - agency name,
  - ownership,
  - organizational relationship with hospital,
  - program focus, and
  - program and service relationship with hospital;
- health goals of the community;
- health needs of each functional community and prioritization of these needs;
- gaps in services required to meet the health needs of these communities;
- overlaps in services provided to these communities;
- the resources which the hospital (and the third parties to the agreement) intend to bring to bear on these needs, including programs and services, and expected outcomes;
- programs and services to be rationalized by the hospital (and other agencies) including
  - new programs and services,
  - enhancements,
  - expansions,
  - contractions,
  - transfers to and from the hospital, and
  - eliminations;
- the mechanisms through which the programs and services of the hospital are to be integrated or coordinated on an operational basis with those of other agencies to meet specified objectives;
- an implementation plan;

- the mechanisms and procedures to review the social contract over time and to modify it as required to accommodate changing circumstances and objectives;
- the accountability mechanism and procedures through which the contracting parties can review their performance; and
- provision for resolution of disputes.

In the case of hospitals with teaching or research programs, it will be important that their role and relationships with their specialized functional communities be documented and confirmed in their social contracts. These contracts should be subjected to the same public consultation, negotiation and review processes as those of other public hospitals. The processes, however, will likely be more complex because the social contract for a hospital with teaching and research programs should relate to the contracts, plans and affiliation agreements of the other hospitals, health agencies and educational institutions with which the hospital's programs are related.

4.2.6 Duration

The social contract should remain in force for an extended period to ensure continuity and certainty in the provision of services. However, to maintain its relevance, the contract should be reviewed and renegotiated at least every five years. There should be a clause in each contract requiring discussion for a replacement social contract to commence no later than a given date prior to the expiration of the current contract. In this way the social contract becomes a "rolling document' subject to continuing consideration and modification. The negotiations to change or replace the current contract would have regard for the following:

- demographic changes;
- changes in the needs of the functional communities;
- prioritized unmet needs;
- changes in health care priorities and strategies;

- changing relationships with other providers, including proposed changes in programs and services; and
- changes in financial conditions.

One of the implications of a social contract with an extended duration is the need of the hospital (and other participating agencies) for secure funding. Without some reasonable degree of certainty from the province regarding funding, the hospital cannot be expected to enter into the long-term program and service commitments of a social contract. We recommend that the government consider multi-year funding arrangements for hospitals (see Chapter 10).

Recommendations:

We recommend that:

(4.01) The Public Hospitals Act should require each hospital to develop a social contract.

(4.02) The Ministry of Health should ensure that mechanisms and procedures necessary for the development and operation of social contracts are in place in each district or region.

(4.03) The Ministry of Health should specify in statute or regulation the role of the district health council, or other designated agency, as broker in the process of developing social contracts.

(4.04) The Public Hospitals Act should stipulate that social contracts provide for the education and research activities and affiliation agreements of hospitals.

4.3 RESOLVING DISPUTES

Inevitably, from time to time, issues arising out of social contract discussions will resist facilitation and mediation. In the end, these issues will be resolved only by some objective third party. Thus, social contract negotiations which have not been

successfully brokered by the council, when all else fails, should be referred to a Social Contract Conciliation Panel to be established by the Minister of Health.

The Panel should be composed of objective people, perhaps five in total (although a larger membership might be necessary at the outset to deal with the number of social contracts that will have to be developed at the outset). Its members would not include representatives of government, but be drawn from the ranks of people experienced in health planning, hospital planning and health service delivery. The membership should include people who can bring to the conciliation process experience from the perspective of both consumers and providers, from institutions and from the community. The Social Contract Conciliation Panel should be served by a small number of experienced, competent staff to ensure that it can deal expeditiously with disputes referred to it.

Referrals to the Social Contract Conciliation Panel would be made by the Minister of Health on the receipt of advice from a district health council (or equivalent planning body) that it had been unsuccessful in arranging the development of a social contract. The Panel would deal with unresolved issues around program and service delivery and attempt to conciliate among the disputing parties. If conciliation were not possible, the Panel would recommend a solution to the Minister of Health for implementation. The Panel's recommendations would have to take into account available resources and the hospital's ability to provide services. The Panel would not deal with detailed issues related to hospital operations or financing, which are the responsibility of the hospital and the Ministry respectively. The Social Contract Conciliation Panel's recommendations would inform and advise but not be binding on the Minister of Health. In the end, the Minister would decide.

Recommendations

We recommend that:

(4.05) The Ministry of Health should establish a Social Contract Conciliation Panel charged with resolving disputes with regard to social contracts and making recommendations to the Minister of Health on unresolved issues.

CHAPTER 5 GOVERNANCE

5.1 INTRODUCTION

Governance is the exercise of authority, direction and control. Currently, most hospital boards work well. But, the present Public Hospitals Act does not provide the boards with sufficient direction on hospital governance.

For example, there does not appear to be a common understanding among hospital boards of what governance means in relation to management. Some hospital boards are heavily involved in the day-to-day management of the hospital. Some boards leave to management decisions which are properly the responsibility of the board on fundamental policy issues affecting the long-term viability of the hospital. Similarly, there does not appear to be a common understanding among hospital boards, staff or the Ministry of Health of the responsibilities of governance with respect to the relations between the hospital and other stakeholders. It is essential that these uncertainties around hospital governance be resolved.

Given the diversity of Ontario hospitals and the differing communities they serve, it is unrealistic to assume that a detailed prescriptive approach to governance will work. At the same time, the public is entitled to some reasonable degree of certainty that the province is providing consistent guidelines to all hospital boards about minimum standards for the governance of hospitals.

5.1.1 Voluntary Governance

In Ontario, there is a long tradition of governance by interested and informed volunteer boards with an intimate relationship to the community being served, a working relationship with other providers, a reliance on public funding but a distanced relationship from government. This tradition of voluntary governance of public hospitals distinguishes Ontario from many other health care jurisdictions outside Canada.

Despite the great diversity among Ontario's public hospitals, the voluntary governance structure has not changed much over the years. With few exceptions, the boards of

directors of all our hospitals - large and small - consist of local citizens from the communities in which the hospitals are located, plus members of the medical staff.

The Public Hospitals Act is not just a piece of legislation about hospitals. It is an expression of an inherently Canadian value; the willingness of interested citizens to give generously of their time to serve the public interest. What encourages hospital board members to strive for excellence is that intangible sense of public spirit and the desire to play a part in the leadership of one of the community's largest and most important institutions, as well as one of its largest employers. The legislation needs to recognize individual board members' personal pride in the hospital and their belief that their participation can make a genuine difference to community well-being, and provide them with the flexibility they need to strive for the hospital's success.

As a general principle, the public interest, both local and for the province as a whole, will continue to be well served by volunteer boards attuned to community needs and at arms-length from government.

5.2 RESPONSIBILITIES OF GOVERNANCE

5.2.1 Establishing a Basis for Accountability

Accountability must lie at the heart of Ontario's public hospital system. It is important, therefore, for the Public Hospitals Act to define both those special characteristics of the hospital which differentiate it from other health care providers and facilities, and the key accountabilities of the hospital sector: the accountability of the hospital board to its corporation, of the hospital to the patient, community and province, and of the provincial government to the electorate.

Corporation. The majority of public hospitals in Ontario are independent corporations, incorporated under Part III of the Corporations Act which deals with organizations which operate without profit to their members (not-for-profit). Some hospitals are owned by municipalities, others by religious organizations. As a matter of principle, the Public

Hospitals Act should require that all hospital boards ensure that their hospitals are incorporated because incorporation ensures that there is a legal entity which can be held accountable.

Earlier, we referred to the principle of the hospital's accountability to the patient and public. In the first instance, however, the board is accountable to its corporation. When an individual becomes a member of a hospital board, she or he is expected to represent the interests of the hospital corporation first. It is the corporation which is accountable for the actions of the board and for ensuring that the board directs the hospital so as to fulfill its multiple responsibilities, including those to the patient, community and province. Incorporation of the hospital, therefore, is the first and essential step in establishing accountability.

Not for Profit. There are both for-profit and not-for-profit health services in Ontario. Historically, most public hospitals in Ontario have belonged to the not-for-profit or charitable sector. This situation is suited to the public health insurance program in Ontario. As a matter of principle, all public hospitals in Ontario should be not-for-profit.

Purposes. A hospital can serve many purposes in its community. At its core, however, the purpose of each hospital, which distinguishes it from other health service providers, is that it focusses primarily on the diagnosis, treatment and care of illness, disability and trauma on both an in-patient and out-patient basis.

Relationship to the Health Care Sector. All health service providers operate within the health care sector. The hospital, however, manifests that relationship more strongly because the hospital integrates a wide range of health services within its own walls, and through its relationships with providers in the community. The purposes of the Public Hospitals Act should be to clarify, support and guide that relationship.

Recommendation

We recommend that:

(5.01) The Public Hospitals Act should require that each public hospital, (1) be a separately incorporated institution, the incorporation of which is approved by the Lieutenant Governor in Council; (2) be a broadly defined facility which focusses on the diagnosis, treatment and care of illness, disability and trauma on an in-patient and out-patient basis; (3) operate on a charitable, not-for-profit basis; (4) provide members of the public with health services; and (5) function within an integrated health services system.

5.2.2 Purposes and Principles of the Hospital

There is a powerful public interest in ensuring that all hospitals, health care professionals, the provincial government and the general public have a common understanding of what is meant by governance and of the responsibilities of the hospital's board with respect to governance. Governance is the responsibility of the hospital's board of directors. Governance can be thought of as the right and responsibility of the hospital board: a) to determine the hospital's purposes and principles, including the hospital's goals and objectives, values and policies by which it will function over the long-term as a self-governing organization; and b) to arrange for its management accordingly. The purposes of the hospital are its mission, what it seeks to accomplish; the principles are the context. Both are extremely important in institutions like public hospitals that have exclusive rights to operate in the public interest, essentially as participants in a publicly-funded, regulated monopoly.

The public is also entitled to some assurance that the public agenda is predominant in the governance of Ontario's public hospitals, and that the Public Hospitals Act prescribes a framework within which hospitals serve as good "citizens" within their communities and the provincial health care system.

The responsibilities of governance include:

- defining and maintaining the purposes of the hospital, including its goals and objectives with respect to such matters as the hospital's mission, quality of patient treatment and care, relations with professional and other staff, the community and province, reporting relationships, public access and accountability;
- defining and maintaining the principles of the hospital, including the values, culture and ethical environment, and of its relationships to its patients, to the community or communities it serves and to the other providers and stakeholders in the health services system;
- defining and ensuring the long-term future of the hospital, including its social contract and its fiscal integrity;
- ensuring and monitoring the effective management and financial health of the hospital; and
- ensuring and monitoring the quality of services and continuing improvement of quality in all aspects of hospital operations.

The Public Hospitals Act should provide guidance to hospital boards regarding these and related responsibilities. The intent of such guidance is not to bind hospital boards or their members to a particular action, but to enable them to determine for themselves, within a consistent and comprehensive framework, how best they will fulfill their responsibilities.

5.2.3 Governance and Management

The Public Hospitals Act should specify the distinctions between governance and management in legislation in a more comprehensive and consistent manner than is now the case. Basically, governance deals with what an organization is to do; its vision, mission, principles and purposes; while management deals with how these are to be accomplished.

Inevitably, there are shades of grey between governance and management because the two are complementary. There are also activities which the board and management carry

out jointly, such as strategic planning. Nonetheless, the differences between governance and management are distinct, need to remain so and should be incorporated in the Public Hospitals Act. The board's authority is rooted in its relationship to its functional communities and its ultimate responsibility for the long-term viability of the hospital.

It is not the responsibility of the board to engage in the day-to-day or week-to-week management of the hospital. The board is responsible for ensuring the people, resources and procedures are in place to manage the hospital effectively and implement the board's policies; for monitoring management's success in carrying out these policies; and for taking the steps necessary to ensure that progress is sustained. This includes the board's right and responsibility to approve the annual operating plan and budget as key instruments of management and long-term planning. The board also has the responsibility to hire, evaluate and, when required, terminate the services of the hospital's chief executive officer.

Management's authority derives from the board. Management is focussed on the development and implementation of strategies and the means to achieve the hospital's goals and objectives and, thereby, serve its overall mission as established by the board. Management is accountable to governance.

Recommendations

We recommend that:

(5.02) The Public Hospitals Act should stipulate the respective responsibilities of hospital governance and of hospital management.

(5.03) The Public Hospitals Act should specify that governance is the responsibility of the hospital board of directors.

(5.04) The Public Hospitals Act should state that the responsibilities of the board include: defining and ensuring the long-term future of the hospital; defining the principles, purposes, goals and objectives of the hospital, including its social contract; arranging

for and monitoring the effectiveness of the hospital's management; and approving the annual operating plans and budgets of the hospital.

5.2.4 Quality of Care

The primary purpose of the hospital is to serve the patient; and a fundamental responsibility of governance is for the quality of patient care and services. The board must set the policy directions for quality improvement in the hospital, and foster an organizational culture that promotes and supports the commitment to continuous improvement of both the quality of clinical services and the general management and operation of the hospital.

The board must ensure that continuous quality improvement is embedded in the hospital's culture, policies and procedures. The board should demonstrate its commitment by incorporating the goal of continuous quality improvement in the hospital's purposes and bylaws. The bylaws should ensure an effective committee structure at both the board and the management levels for quality improvement involving all hospital staff and employees. The board's committee structure should include a committee of the board responsible for quality of patient care and service and quality improvement.

The Quality of Care Committee's (QIC) responsibilities should include:

- ensuring that appropriate structures and processes are in place to maintain and improve quality and to monitor the effectiveness of such structures and processes;
- reviewing and advising the board on quality improvement plans submitted by the hospital management; and
- reviewing reports from hospital management on quality and advising the board on the quality of the hospital's services and the effectiveness of its quality improvement efforts.

The board committee responsible for quality improvement, although it would not be involved with individual patient service, should include representation from the Patient

Services Function (see Chapter 9) so as to underscore the importance of customer service and satisfaction, .

Recommendations

We recommend that:

(5.05) The Public Hospitals Act should stipulate that hospital boards are accountable for the quality of hospital services and care.

(5.06) The Public Hospitals Act should require hospital boards to incorporate a commitment to continuous quality improvement in their mission statement.

(5.07) The Public Hospitals Act should require hospital boards to establish bylaws to involve all staff and employees in maintaining and continuously improving the quality of patient care and services.

(5.08) The Public Hospitals Act should require each hospital board to establish a Quality of Care sub-committee of the board to make recommendations to the board with respect to quality improvement activities and quality of patient care and services.

5.2.5 Ethics

An emerging focus of quality improvement activity is the ethical behaviour of the hospital. It is important that hospitals behave ethically in their commercial affairs, in their relations with their staff, and in their delivery of patient care. Because of the public trust placed in them, hospitals need to infuse ethics into all their activities and behaviours. The board is responsible for defining the organization's principles and values and for ensuring that management and clinical processes reflect these principles and values. More specifically management should establish an ethics program to provide a framework for ethical decision making, and as a resource for understanding the ethical implications of both clinical and management decisions.

Hospitals are entrusted with the well-being of their patients. Decisions of the hospital's clinical processes affect the quality of life of the patient. There are many varied and often complex ethical issues that frequently need to be addressed in selecting an ethical approach to clinical decisions. There are, for example, ethical issues around quality of life and resuscitation, issues which were less complex and troublesome in the days when life-sustaining technology was less effective. These types of issues have created ethical challenges for clinical processes, clinicians and health care organizations. The issues are further complicated by the varied sets of professional ethics that are brought to the care processes of the hospital by the different clinical disciplines that participate in the care of its patients.

Setting the ethical framework for any organization is not easy. The primary test of any approach to the hospital's ethical context has to be the extent to which the patient benefits directly or indirectly. It is not appropriate that a cumbersome structure or process be created to absorb the time of professionals, management and other staff, to deal with ethical issues. Rather, the actual behaviours through which ethical issues are best identified and resolved need to be spread throughout the operations and management of the hospital.

It seems most useful to look first to developing an orientation in the hospital to ethical concerns and to build on that base. This orientation would be built by encouraging behaviours rather than by compelling adherence to rules. It would attempt to create a climate which recognizes different values regarding health care decisions. It would provide for reconciliation of the preferences and requirements of patients with the health care recommendations of the professionals. Above all, it would foster an atmosphere conducive to collaboration and patient involvement. This orientation requires several complementary approaches.

Multi-stakeholder management. This involves a mechanism to facilitate communications, consultations and collaboration among the different health care providers with respect to the patient whose well being is the primary concern of all those involved.

Patient Advocacy. This includes a means to ensure patient participation, representation and advocacy in matters affecting the patient, and to resolve or reduce conflicts concerning the patient, the providers and the hospital.

Ethics Training. Health care providers, staff and management must develop a common understanding of ethical issues and agree on ways to resolve these issues.

Some ethical issues are more pressing than others in terms of their gravity with respect to patient well-being, the consequences for the patient of the decision and the time available in which to make the decision. Hospitals should establish an ethics program as one of the underpinnings of the management and clinical processes of the hospital. An effective ethics program should have the following characteristics:

- an enabling statement concerning ethics against which the practices of the hospital may be measured;
- a reflection of interdisciplinary and community needs;
- the availability of opportunities for ethics education for the hospital providers, patient and their families;
- access for the providers, patients and their families to discussion of ethical matters;
- an ongoing review process of the ethics program; and
- accountability to the board through the CEO's responsibility for the management of the organization.

The ethics program should focus on achieving social, working and clinical environments in which difficult issues can be addressed and resolved. An ethical orientation throughout the hospital will contribute to greater respect for the rights of patients and providers.

Recommendations:

We recommend that:

(5.09) The Public Hospitals Act should require hospitals to develop an ethics enabling statement.

(5.10) The Public Hospitals Act should require hospitals to establish and maintain an ethics program.

5.2.6 Planning

Planning is essential to governance. Plans reflect the board's decisions on the future of the hospital, its purposes, goals and objectives and provide direction to management. Until recently, many hospital boards tended to treat planning mainly in terms of facility planning. These boards tended not to involve themselves in long-term or strategic planning, nor in coordinating this planning with that of other hospitals or providers in the community. The result was that a number of hospitals often found themselves having to make policy decisions about programs and services on a reactive basis because they had not developed a planning framework.

There are several levels of planning which the board should address as part of its governance obligations:

- the "social contract" with the community, in which the hospital agrees to the services it will provide, and to collaborative and cooperative arrangements with other hospitals and providers;
- strategic and other planning activities related to development and implementation of the hospital's social contract, its missions and roles and long-term fiscal management; and

- short-term operational planning and budgeting incorporating the programs, services and activities proposed by management for the current fiscal year as part of long-range and strategic plans and the social contract.

The social contract starts with planning. To be effective, the hospital's planning needs to be a continuous, cyclical process which involves the other stakeholders including the community, the district health council, other providers and Ministry of Health. Planning needs to be coordinated with other providers and the district health council.

Each hospital's plans should be formulated within the context of provincial and district or regional health goals and strategies. The Ministry of Health will have to define the processes for reviewing and approving hospital plans. These review and approval processes should be incorporated into the review procedures of the district health councils and of the social contract. New legislation, in addition to the Public Hospitals Act, will be required to set in place this system-wide approach to planning and plan review and approval.

Once the hospital has filed its plans, the planning approval process would come into play. Ministry guidelines will be required to outline the range of providers to be included by the hospital in its planning, and the meaning of cooperative and consultative planning. Some aspects of hospital's long-term planning which are specific to that hospital may still need separate review and approval by the Ministry.

Recommendations

We recommend that:

(5.11) The Public Hospitals Act should state that boards of public hospitals are accountable for ensuring that planning and development of programs and services take place, and are coordinated and integrated with, the activities and plans of other providers through provincially-mandated planning processes.

5.2.7 Hospital Staff

The board has important obligations to its staff. The board must establish principles, purposes and policies for the hospital which unify the many professions, disciplines and occupations in the hospital in a common vision and purpose. It must set policies which ensure that the hospital is managed and operated so that the various professionals can conduct themselves in keeping with their professional standards and requirements, and that other staff can carry out their responsibilities effectively and efficiently. The board must set policies which ensure that the hospital is maintained as a safe working environment and managed in keeping with good labour relations practices. The board has other obligations, difficult to specify in legislation, to treat its regulated health professionals and other staff with respect and to foster a dynamic, interactive working environment which transcends traditional boundaries among staff and is the basis for a healthy organization.

The board has an additional responsibility to set policies that enable staff to participate in decision-making based on the multidisciplinary template which characterizes patient care and services. Historically, only physicians have had legislated access to the hospital board, both as voting members and in an advisory capacity. The contemporary hospital board, to be successful, must generate and provide the means by which staff, both regulated professionals and others, can participate appropriately in the separate functions of hospital governance and management.

5.2.8 Fiscal integrity

The board is responsible for the fiscal integrity of the hospital and its long-term solvency, including raising money to support hospital activities not covered by provincial funding. The long-term fiscal integrity of hospitals has become an issue of increasing concern. Every year a number of hospital boards report that their accumulated debt from continuing deficits exceeds their ability to repay, and that the cost of servicing the debt is effecting their ability to provide services. This is not good stewardship of public and charitable funds and not in keeping with the board's long-term obligations to its community.

Legislation which required hospitals to balance their budgets is impractical. The hospital board cannot guarantee that an annual budget will accommodate all unforeseen circumstances in that year. Sometimes a deficit is necessary and useful as part of a hospital's development program. Where a board agrees to a deficit, it must also, as a prudent trustee of a public institution, have a business plan for dealing with that deficit within a specified period of time.

Legislation can play an important role, however, in clarifying and sharpening the board's accountability for monitoring and ensuring effective fiscal management, and discouraging boards from not fulfilling their fiscal responsibilities. The new Act should require hospitals to incorporate fiscal considerations into their long-range planning and strategic planning, as many hospitals already do, and to require an annual operational plan as the context for the annual operating budget. The board should be required to secure from management, at regular intervals during the year, reports on the fiscal management and fiscal integrity of the hospital and its operations.

5.3 PRINCIPLES OF BOARD MEMBERSHIP

The Regulations (518/88) under the current Public Hospitals Act stipulate the role of physicians on the board of directors. There is no reference in the Regulations to representation on the board from the other professions or from staff in the hospital or from the community which the hospital serves.

Times have changed. The hospital is more than ever a public institution and community resource. It is appropriate to revisit the principles of board membership from the perspective of the community, regulated health professionals and other hospital staff. The voluntary governance model needs to be strengthened. Many hospitals are more than local resources. Many hospitals, particularly those which deal with long-term illness and those which are teaching hospitals, must interact with a large spectrum of functional communities. The governance of these hospitals should reflect this broader reach.

5.3.1 Community

As a matter of principle, board membership should be drawn widely to reflect the composition of the various functional communities and interests which the hospital serves, and to provide on the board the skills it requires to carry out its responsibilities. This principle speaks to the concept of a broadly-based approach to the election or appointment of members of the board. Once on the board, members are expected to act in the best interests of the hospital rather than of the constituency from which they were elected or appointed.

There does not seem to be any advantage to specifying in legislation or regulation whether board members are to be appointed or elected, or how such a appointment or election should be carried out. Hospitals serving different types of communities, and with different traditions, cultures and values will address representativeness differently. The board will want to look at such considerations as how to use the membership of the hospital corporation and of the board itself as ways to achieve an appropriate mix of skills and representativeness; how to achieve representativeness if the corporation is closed; the combination of election and appointment procedures; length of tenure and openness to change in the board membership.

It is difficult for any group of individuals, no matter how selected or elected, to represent and reflect fully the broad range of individuals, groups and interests which make up a community. That is one of the enduring challenges of democracy, and one which every hospital needs to address.

Each hospital board should be required to set out in bylaw the procedures for the election or appointment of board members. The following are examples of the kinds of criteria for board membership which boards should consider in developing these bylaws:

- people who reflect the history, tradition, values and mission of the institution, and who will remain consistent with those qualities as the hospital's plans and operations develop in accordance with changing circumstances;

- people drawn from and reflecting the breadth of the community or district served;
- people with experience in governance or management who can provide informed judgement on the efficiency and effectiveness of the hospital's operations and management; and
- people who reflect ownership (where that is separate from the hospital corporation represented by the board), affiliation with universities (in the case of hospitals with teaching and research programs) and other related institutions.

Membership on the board is only one of the ways the board strives for community representation in its deliberations. Other methods include special advisory committees, committees made up of other service providers and agencies in the community, and coordination with the district health council and other planning agencies. The board should ensure that it takes these, and other appropriate avenues, into account in developing a process which reflects the characteristics of its functional communities.

5.3.2 Professions and Staff

The Steering Committee has reviewed the opportunities for board representation available to physicians under the regulations of the current Public Hospitals Act and the scarcity of comparable opportunities for other regulated health professions and other hospital staff. Some professions wish to have representation on the board. Other professions prefer that neither professional nor non-professional hospital staff be represented on the board. The Steering Committee believes that it is necessary to define the principles which should govern the relationship between the board and all hospital staff, and to encourage equitable access to the board for all staff.

The starting principle is that the hospital is a public institution with a corporate purpose to serve the interests of the patient and community. The several interests of the professionals, management and the staff are among the many interests the hospital board has to balance to meet its over-riding corporate purpose.

It is vital to ensure the primacy of the hospital's corporate interests among all members of the board. Thus, members of the board should not have actual or perceived interests or commitments which may conflict or be perceived to conflict with the hospital's corporate interests. Voting members of the board should be distanced from vested interests within the hospital itself. Adherence to this principle avoids the potential for conflicts of interest or commitment, and ensures the primacy of the hospital's corporate interest among all members of the board. Boards constituted on this principle would exclude from membership physicians with privileges in the hospital, all other regulated health professionals in the hospital, management and all other members of hospital staff.

The application of these principles does not imply that hospital staff should be denied access to the board, or that the board should carry out its responsibilities without the advice, experience and guidance of regulated health professionals, managers and other hospital staff. Rather, the Public Hospitals Act should acknowledge the vital advice which staff can offer to governance and require that staff have access to the board. Such access can be ensured on a comprehensive and equitable basis to all staff through a legislated advisory structure to the board. It is not necessary to be a member of the hospital board to participate effectively in the processes of governance.

5.3.3 Management

In some public hospitals in Ontario, the chief executive officer (CEO) is a member of the hospital board. In our view, the CEO should not serve on the board. It is not appropriate to have any member of management sit on the hospital board for the same reason that physicians, other health professionals and other staff should be excluded: the need to avoid actual or perceived conflicts of interests on the board.

Even so, the CEO must be easily available and have on-going access to the board. The CEO carries the authority of the board in implementing its policies; is a major source of leadership, advice and guidance on planning, service delivery and policy development at both the staff and board level; is the major conduit of information from the board to staff; and often is required to speak for the board while remaining answerable to it. The CEO is

the board's principal and most responsible agent in interpreting, implementing, monitoring and reporting on the implementation of the board's policies, plans and values.

For the CEO to fulfil these many and diverse responsibilities, a special relationship must exist between the board and its chief executive officer. Open, unfettered consultation and communication between the board and its CEO is essential if the board is to discharge its governance responsibilities. Therefore, the CEO must not only be entitled but expected to attend and participate in all meetings of the board (except in rare circumstances) either personally or through a representative. In this model, the CEO is free of real, potential and perceived conflicts of interest.

A Public Hospitals Act, as legislation specific to hospitals, which stipulated this restriction on CEOs would take precedence over the Corporations Act. Subsection 289(1) of the Corporations Act requires that the directors of a corporation elect a president from among themselves. To override this requirement, the Public Hospitals Act need only stipulate that "notwithstanding the Corporations Act, the President of a public hospital corporation need not be a director of the corporation".

Recommendations

We recommend that:

(5.12) The Public Hospitals Act should stipulate that hospital boards be drawn entirely from the communities served by the hospital.

(5.13) The Public Hospitals Act should stipulate that the hospital board must set out in bylaw the criteria and procedures by which persons will be elected or appointed to the board; that these criteria and procedures facilitate board membership which reflects the communities the hospital serves, and provides the skills the board requires; and that the bylaw requires approval by the Ministry of Health.

(5.14) The Public Hospitals Act should stipulate that no person appointed to or employed by a hospital can serve as a member of that hospital's board of directors.

5.4 ADVISORY COUNCILS

5.4.1 The Basis for Change

It is in the public interest to develop a comprehensive advisory structure for the board; one which ensures that the board has advice from all staff, whether appointed or employed, and from the functional community or communities of the hospital. The Public Hospitals Act should require that all public hospital boards have at least the following three Advisory Councils:

- Community Advisory Council;
- Professional Advisory Council; and
- Employee Advisory Council.

The implementation of such an advisory council structure would be a major expansion of the board's access to advice and counsel, and of the access of hospital stakeholders to the board with respect to its governance responsibilities. This advisory structure represents the application of the principles of comprehensive and equal access to the board of its major stakeholders, and of partnership and collaboration within the hospital and between the hospital and its community.

Some small hospitals may find it cumbersome to have three separate advisory councils; other hospitals may wish to have more than three advisory councils. The principle should be maintained in such arrangements that, at a minimum, there are at least three main groups from which the board requires advice. Hospital boards which propose to reduce the recommended tripartite advisory structure should be required to set out their reasons and seek the approval of the Minister of Health.

5.4.2 Responsibilities of Advisory Councils

The responsibility of the Advisory Councils would be to provide advice and information to the hospital board on all matters pertaining to governance, including:

- the hospital's social contract, mission, goals, objectives and plans;

- existing and proposed programs and services and proposals for new and expanded programs and services;
- quality of care and quality improvement in all aspects of the hospital's activities;
- social, political and environmental issues about which the board requires information to fulfil its role, such as government policies, legislation, economic factors, technological advances, professional issues and changing community needs; and
- effectiveness of management in achieving the objectives of the hospital, insofar as the issues fall within the ambit of governance.

Advisory Councils should have direct access to the hospital board through the Councils' chairpersons or other delegated representatives who would attend all board meetings, except when issues such as staff negotiations are on the table. Representatives would be entitled to comment freely on all matters pertaining to governance.

Advisory Councils are not intended to be a forum for questioning or second guessing individual decisions of management. The Councils are intended to deal with the broader issues of governance which are the responsibility of the board, and to deal with management issues only insofar as the related policies fall within the ambit of governance. At the same time, the Advisory Councils can be a valuable resource to the CEO and management, for example, in such areas as policy development, planning, quality improvement and evaluation. The relationship between the CEO and management and Advisory Councils need not and should not be adversarial. The board should encourage its Advisory Councils to play an advisory role to the CEO and management as needed.

Sound governance practices require that management be informed beforehand about Advisory Council reports, commentaries and recommendations to the board. It is in the board's interest to have the advice of management available when these matters are raised. The board should require Advisory Councils to advise management before bringing issues to the board. This advice is intended solely for the purposes of informing management and not to seek the approval of management.

5.4.3 Community Advisory Council

It is important that the hospital board seek advice and information directly from as many sectors as possible of the community. The Community Advisory Council (CAC) is one of the ways the board reflects the larger community. Through the CAC, the board demonstrates to the hospital's functional communities its commitment to reach out and secure the involvement of the community in the hospital's governance.

The CAC's mandate should pertain primarily to community issues and the social contract, and include the following:

- advising the board regarding ongoing assessment of community health care needs in relation to the social contract;
- advising the board on the development of strategies for meeting community health care needs within the terms of the social contract;
- monitoring, assessing and advising the board on the hospital's fulfillment of its social contract; and
- promoting community involvement and participation in decision-making regarding planning and evaluation.

CAC members would be drawn from agencies, organizations, associations and neighborhoods which are themselves reflective of the ethnic, cultural, demographic and health characteristics of the community and its service needs. Hospital board members, employees and professionals affiliated with the hospital, with the exception of a representative from the hospital's Patient Service function, would not be eligible for membership on the CAC.

For the CAC to be effective, persons who might otherwise have difficulty participating may need help from the hospital; for example, by payment of travel expenses, timing of meetings and child care.

5.4.4 Professional Advisory Council

All regulated health professions should be ensured an equal right to advise the board on matters relating to governance. The first responsibility of the Professional Advisory Committee (PAC) should be to advise the board on those matters involving patient services and quality which pertain to governance.

The PAC would be a multi-professional advisory body which embodies the principle of the hospital's multidisciplinary approach to programs and services. The PAC would be made up of representatives from all regulated health professionals on the hospital staff, both those employed by the hospital and those not employed by the hospital. The members of the PAC would be elected or appointed from among the hospital professionals to create a broadly representative body. The means by which professionals are elected or appointed as PAC members should be set out by the board in its bylaws.

The creation of PAC raises a number of issues which each board will need to address. One is that members of different professions may be divided on an issue. In such cases, the PAC may not be able to act in an advisory capacity and the board might have to hear from representatives of the individual professions.

Another potential issue concerns the differing sets of interests of those regulated health professionals who are entitled to admit patients or register outpatients and those who are not. Those regulated health professionals who can admit or register patients may depend on their appointment for their livelihood; these professionals also have a major effect on the demand for hospital services and, consequently, on hospital costs. More broadly,

regulated health professionals who can admit or register patients have a different perspective than those who cannot with respect to patient care and services and to the role of the hospital in the community. The board needs access to both these perspectives within the overall collaborative context of the PAC.

Given the importance of this issue to the hospital and the regulated health professionals, the Public Hospitals Act should stipulate that the PAC establish two sub-committees. One should be made up of regulated health professionals, regardless of their employment status in the hospital, who admit or register patients. The other should consist of regulated health professionals who do not admit or register patients. Each board will want to review its particular circumstances to determine if other subcommittees of the PAC are required.

5.4.5 Employee Advisory Council

The complexities of hospital governance require that the board also has regular access to the advice of its employees who are not members of a regulated health profession. Such employees should have advisory status at the board table equal to that of the regulated health professionals and the community. When setting the procedures for the creation and operation of the Employee Advisory Committee (EAC), the board should take into account the characteristics of its employees: supervisory, worker, union, non-union, technical and non-technical. Like the other advisory councils, the EAC should not deal with issues pertaining to day-to-day management of the hospital or to employment contracts.

Recommendations

We recommend that:

(5.15) The Public Hospitals Act should require that each hospital board establish a formal advisory process to the board; that this process include at least the following advisory councils; Community Advisory Council, Professional Advisory Council, Employee Advisory Council; and that these Councils have the right to communicate directly with the board on all matters related to governance.

(5.16) The Public Hospitals Act should require each hospital board to establish two sub-committees of the Professional Advisory Council; one consisting of regulated health professionals, regardless of their employment status in the hospital, who can admit patients or register outpatients; and one made up of regulated health professionals, regardless of their employment status, who cannot admit or register patients.

(5.17) The Public Hospitals Act should require each hospital board to establish procedures for the election or selection of members to Advisory Councils, for the effective operation of Councils and for their funding.

5.5 ACCOUNTABILITIES OF THE BOARD

5.5.1 Issues of Accountability

The current Act does not specify to whom the board of directors is accountable and for what. This lack of definition has contributed to the uncertainties around hospital governance. The purpose of specifying in legislation the accountability of the hospital board is to provide the board and its members with a clear understanding of what they are accountable for and to whom. The issue of board accountability speaks to the balance of diverse interests within the individual hospital, and within the hospital system; the balance between the responsibility of the board for ensuring the delivery of the treatment and care at the individual hospital; and the responsibility of the province for maintaining, coordinating and legislating the hospital system and the health care system.

Balancing the need to specify the multiple accountabilities of the board is the need to be vigilant about protecting the freedom of the board to meet its responsibilities as it deems best. Only with this freedom is it possible to attract the calibre of board members hospitals need, and to challenge board members to make decisions that will truly affect and improve their hospital and the quality of services it provides.

5.5.2 Accountability: Who is Accountable To Whom? For What?

The hospital board, through its governance functions, is the accountable entity for all aspects of the hospital.

The Board may delegate responsibility and authority for particular functions, and is expected to do so for the hospital's management and for patient treatment and care. It will hold accountable those individuals to whom it has delegated responsibility and authority. The Board cannot delegate or deny accountability itself. In terms of accountability, the "buck" stops with the Board.

In any discussion of accountabilities, therefore, in answer to the question of "who is accountable", the board of directors, acting for the hospital corporation, is always ultimately accountable.

The Board is accountable to a number of different constituencies, for example:

- the hospital corporation;
- patients;
- members of the public in their local or regional communities;
- the owners of the hospital, lands and buildings;
- third parties purchasing services from the hospital (such as Workers Compensation Services and Veterans Affairs);
- hospital contributors, whether of capital funds or of volunteer labour;
- all hospital staff, whether or not employed by the hospital;
- other hospitals and institutions with which the hospital relates in the provision of services;
- the district health council or other provincially-mandated bodies responsible for planning, developing or operating the system of hospitals and other health facilities and services; and
- the provincial government which provides the funds for the hospital to function.

All these constituencies are important. It is the board's responsibility to achieve an acceptable balance among them. The priority, specifics and rigour of accountability assigned by a board to each will vary depending on local circumstances.

5.5.3 Primary Accountability

The primary accountability of board members is to the hospital corporation for the following:

The Organization

- the continuing ability of the hospital to serve its communities as an independent, accredited and self-governing entity, and
- advocacy on behalf of the hospital;

Quality of Care

- goals and objectives to maintain and improve the safety, quality, appropriateness and effectiveness of the services provided by the hospital, and
- achievement of the specified goals and objectives;

Fiscal Integrity

- continuing financial viability of the hospital,
- financial planning and budgeting,
- annual budgets, and
- advocate of the hospital for funding from government and non-government sources;

Planning and Operations

- primacy of the public agenda,
- overall direction of the hospital, purposes, long-range, strategic and operational planning, and review and approval of these plans,
- values of the hospital,
- the hospital's social contract, coordination of development plans with other hospital and institutions providing services to the community, district or region served by the hospital, and
- public needs and concerns, including establishing and maintaining its advisory structures;

Management Effectiveness

- management effectiveness, including appropriate and effective participation of regulated health professionals and other staff in management processes,
- development and implementation by management of strategies, structures and programs to achieve the hospital's objectives, and
- the safety, effectiveness and efficiency of hospital operations;

Volunteers

- recruitment and effective participation of volunteers;

Support Services

- the resources necessary to support the services and programs offered within the hospital's social contract;

Working Environment

- the health and safety of the work environment, including compliance with occupational health safety and labour legislation, and
- compliance with other legislation bearing on other aspects of the working environment in the hospital's operation, including employee-employer relations and relations with professional bodies.

Education and Research

- facilities and services, where this is appropriate, to support the education of future health professionals and researchers and research; and

Ethics

- orientation to ethical concerns and behaviour in all aspects of the hospital's management and operations.

It is the responsibility of the board to ensure that each of these accountabilities is incorporated in hospital bylaws, written procedures or guidelines.

5.6 A PUBLIC PROCESS

Given the scale of public funding of hospitals, and the critical role hospitals play in the lives of individuals and the community, there is a strong public interest in ensuring public access to the board and its deliberations. The Steering Committee endorses the model of public access set out in the Regulated Health Professions Act. In that model, there is reasonable notice of board meetings and all persons are entitled to attend them. Similarly, all persons should be entitled to address the board, perhaps upon written request, and have access to hospital bylaws. The exceptions to public access should be those meetings, or portions of meetings, where the board decides that privacy is required because of such considerations as public security, criminal or civil proceedings, personnel matters or property acquisitions. The board should be required to note in the minutes its reasons for holding a particular meeting or portion of a meeting in camera.

Recommendations

We recommend that:

(5.18) The Public Hospitals Act should require meetings of hospital boards be open to the public, except in specified circumstances such as those involving public security, criminal or civil proceedings, personnel matters or property acquisitions.

(5.19) The Public Hospitals Act should require that all hospital bylaws be public documents accessible on request.

5.7 FOUNDATIONS

Hospital foundations, and other separate corporations, play an invaluable role in the financial well-being of hospitals. In recent years, the conditions surrounding the hospital foundation have become more complex. The existence and activities of hospital foundations should be actively supported but within specified conditions which encourage reporting and accountability. These conditions include:

- the activities of the hospital foundation should be consistent with the approved long range and operating plans of the hospital;

- the hospital should not be allowed to transfer funds to its foundation except for bequests, receipted donations or payment for goods or services;

- the foundation's transactions with the hospital should be disclosed in the annual audited financial statements;

- all hospital foundations should be required to disclose their audited financial statements to the public;

- provisions for the disclosure of the corporate records of the hospital should also apply to its foundations; and

- hospitals that have raised funds through donations and bequests consistent with approved plans may hold the funds for specific purposes.

Recommendation

We recommend that:

(5.20) **The Ministry of Health should define in legislation the conditions within which hospital foundations, or other separate corporations of the hospital, can carry out their activities. These conditions should include the following:**

(a) the activities of the hospital foundation should be consistent with the approved long range and operating plans of the hospital;

(b) the hospital should not be allowed to transfer funds to its foundation except for bequests, receipted donations or payment for goods or services;

(c) the foundations' transactions with the hospital should be disclosed in the annual audited financial statements;

(d) all hospital foundations should be required to disclose their audited financial statements to the public;

(e) provisions for the disclosure of the corporate records of the hospital should also apply to its foundations; and

(f) hospitals that have raised funds through donations and bequests consistent with approved plans may hold the funds for specific purposes.

CHAPTER 6 MANAGEMENT

6.1 INTRODUCTION

The current Public Hospitals Act contains provisions concerning hospital administration and administrators. The Act reflects circumstances, during the period from the 1940's to the 1960's, when hospital affairs were administered to facilitate what today would seem to be a limited range of relatively simple and inexpensive medical services. The current Act expects administration to focus on ensuring that the necessary infrastructure is available to support medical care, on keeping track of what happened and how much was spent. The Act reflects the post-war period of growth in the population, the economy and the hospital sector.

The current Public Hospitals Act provides well for a stage in the evolution of hospitals and hospital administration that required a focus on facilitating clinical care and on developing new and expanding hospital facilities. The Act also reflects an approach to hospital financing wherein patients, their insurers and, subsequently, government reimburse the hospital for the cost of care or the cost of hospital operations. This approach, however, creates little need and little incentive to aggressively manage the content of patient care processes or the resulting cost of hospital operations.

Hospitals have changed and the rate of change is accelerating. Hospitals have come to be among the most complex organizations in society because of:

- the introduction of an array of new, more comprehensive and more complex interdisciplinary diagnostic and treatment processes;
- the introduction of increasingly more sophisticated (and effective) technologies;
- growth in the numbers and types of professional disciplines involved in hospital care;
- financial issues; and
- the management of human resources and labour relations.

Contemporary circumstances require hospital managers to integrate these processes, technologies and health care disciplines into effective and efficient episodes of patient care within a financial framework. The Public Hospitals Act should be redrafted to reflect this requirement. The Act should reflect the need for management to refocus its efforts from facilitating medical care to managing the content and cost of clinical processes. The Act should provide for management processes that integrate the many facets of the hospital into a cohesive whole, and for the collaboration of managers and clinicians necessary if the shift in management focus is to be successful.

6.2 MANAGEMENT AND GOVERNANCE

As we noted in Chapter 3, the complexity of the contemporary hospital requires clear assignment of responsibility for the long-term future of the hospital and for more immediate operational issues. The former is the key to effective governance. The latter is a management responsibility.

The effectiveness and efficiency of hospitals are clearly in the public interest. For hospitals to be effective organizations, it is necessary to assign specific responsibilities to governance and to management, and to give managers the clear authority and responsibility to manage. Management should be recognized in the Public Hospitals Act as a separate function responsible for the effective and efficient operation of the hospital in accordance with the direction set by the board. The only operational responsibility of the board would be arranging for and monitoring the effectiveness of management. Similarly, although managers share a commitment to and a sense of responsibility for the organization, they should not usurp the governance role by independently defining long-range goals or making long-term commitments. Governors should govern and managers should manage. Each should fulfill their respective and complementary responsibilities in an atmosphere of mutual trust and collaboration.

The separation of governance and management increases the importance of the role of the chief executive officer (and senior management staff) as the link between the two. The chief executive officer (CEO) should provide leadership to the organization as a

whole, as most already do, advice to the governance processes and direction to the management processes of the hospital. A primary responsibility of the CEO should be to develop strategies for achieving the board's long-range objectives, and then working with management to implement these strategic initiatives.

A complementary responsibility of the CEO should be to inform and advise the board on the status of the organization and its environment, and on the implications of changes for the short and long-term future of the hospital. To be effective, the CEO must be seen as the chief advisor to the board in determining its objectives, and as carrying the full authority of the board in the implementation of its plans.

6.3 RESPONSIBILITIES OF MANAGEMENT

The primary function of hospital management is to ensure the effective and efficient delivery of hospital services. The term "management" is meant to apply to all those individuals who are given responsibility for a particular clinical or other aspect of the hospital's activities. In performing its functions, management acts on behalf of, reports to and is accountable to the board.

To ensure the effectiveness and efficiency of the hospital, management needs to assume a number of specific responsibilities:

- providing leadership to the entire hospital community in,
  - fulfilling the organization's mission and achieving its objectives
  - applying the organization's values to the management practices and operations of the hospital;
- developing and implementing strategies for achieving the hospital's objectives;
- creating organizational structures and intra-organizational processes which promote participation and communication, support effective and efficient service delivery and facilitate achievement of objectives;
- recruiting and developing staff appropriate to the current needs and long-range plans of the hospital;
- directing and overseeing the delivery of hospital services;

- monitoring and improving the efficiency of hospital services;
- monitoring and improving the effectiveness and quality of hospital services and care; and
- reporting to the board on matters pertaining to the effectiveness of the hospital.

The organizational health and effectiveness of the hospital is dependent on the successful execution of these management responsibilities.

Recommendations:

We recommended that:

(6.01) The Public Hospitals Act should stipulate that the primary responsibility of management is the effective and efficient operation of the institution in accordance with the policy directives of the board.

(6.02) The Public Hospitals Act should require that management be responsible for, and report to the board with respect to, compliance with the Public Hospitals Act and Regulations, other relevant acts and the hospital's bylaws.

6.3.1 Planning

A focus on planning in the health care system is to some extent a new activity. Historically, planning by Ontario hospitals tended to focus on the construction of new facilities. Similarly, hospital planning activities of the Ministry of Health tended to focus on the physical characteristics of the facilities being proposed by the hospitals. As a result, long range and strategic planning by hospitals is relatively new. Until recently, hospitals, as a rule, did not develop formal statements of their objectives or their plans for organizational and program development.

A Framework for Planning. There is a clear recognition of the value of, and need for, hospitals to develop coherent sets of objectives and plans. Planning is recognized as a

critical component of sound hospital governance and management. The hospital should develop plans in response to the identified health needs of the community, and in collaboration with the community and other health care and social service agencies.

Effective hospital planning should include the following basic elements:

- identifying the composite community of the hospitals;
- selecting the health needs of the composite community that might be appropriately addressed by the hospital;
- negotiating a social contract with respect to the appropriate role for the hospital, and its relationships with other providers, in responding to the health needs of the community;
- establishing objectives for the hospital;
- defining and describing the programs and services required to respond to the selected health needs of the functional communities and to achieve the hospital's objectives;
- developing plans and strategies for fulfilling the social contract;
- developing human resource plans to support planned programs and services; and
- translating these plans and strategies into specific activities to be initiated during the next fiscal year (operational planning).

Formal statements of objectives and plans, now recognized as essential to successful governance and management of the hospital, provide a framework for annual operational planning and budgeting. The complexity of the contemporary hospital requires that decisions be made within the context of organizational objectives. Plans for achieving these objectives should be well understood and generally accepted by the organization as a whole and by each of its constituent elements. These planning documents should communicate clearly the hospital's priorities and plans, and can be the basis for cooperative and collaborative activities among all stakeholders to achieve the hospital's objectives.

In keeping with the need to distinguish between governance and management, organizational objectives and long range goals for programs should be considered primarily a responsibility of governance; strategies and operational plans for achieving these objectives and goals should be considered primarily a responsibility of management. Although long-range planning is primarily a responsibility of governance, it is unrealistic to expect that boards can or should undertake it independently. To be useful as management tools, objectives and long-range plans should be developed in collaboration with management and other hospital clinical, administrative and support staff. Leadership and guidance to the long-range planning process will be provided by the CEO and senior management.

Collaborative Planning. As we discussed in Chapter 3, Ontario's hospitals, the Ministry of Health and the public have realized that hospital objectives and plans need to fit into the larger regional and provincial context. They need to be developed in a fashion which takes into account, and responds to, the health and health care needs of the community; the aspirations, plans and capabilities of other hospitals and health care agencies serving the community; and the financial, technological and human resources available to the hospital.

Hospital plans, programs and facilities should be developed, redeveloped and refocused in consultation and collaboration with the community, other providers of health care and social services and other hospitals. This will improve the efficiency and effectiveness of the organization and distribution of hospital services. It will provide for more equitable allocation of and access to health care resources, services, technologies and programs. The proposed requirement for social contracts will reinforce this movement toward more formal, systematic, comprehensive, collaborative and community-oriented planning of hospital programs and services.

Recommendations:

We recommend that:

(6.03) The Public Hospitals Act should require hospitals to develop long-range plans.

(6.04) The Public Hospitals Act should require hospitals to develop their long-range plans in cooperation and consultation with other providers.

(6.05) The Ministry of Health should develop guidelines for cooperative and consultative planning, and for the range of providers to be included in hospital planning.

(6.06) The Ministry of Health should require hospitals to file their long-range plans with the local district health council, or other provincially-mandated body, and the Ministry of Health.

6.3.2 Operational Planning

Operational planning and budgeting are the annual management processes through which the hospital implements its long-range plans and fulfills its social contract. Typically these processes involve establishing:

- annual objectives for the organization;
- plans for the development, enhancement, maintenance, contraction or elimination of programs and therapeutic, diagnostic, support, and administrative services;
- performance expectations related to the volume, productivity, cost and quality of services provided by each program and by each therapeutic, diagnostic, support and administrative service department; and
- targeted expenditure levels for each element of the organization and for the organization as a whole.

The hospital needs an operating plan and related budget to describe and quantify its annual objectives and its planned program, service and fiscal initiatives. The plan and

budget should be reviewed and approved by the board, and thus is one of the most effective vehicles for ensuring the accountability of hospital management and staff to the board, and of the hospital to the community.

Operating Plan. Most hospitals do not prepare formal operating plans. They rely on annual budgets which they use as both operational and financial plans. Formal operating plans, as basis for the annual operating budget, would provide these hospitals with the opportunity to articulate potential initiatives, plans and expectations, formally consider them and either confirm or reject them at the beginning of each year. Operating plans also provide a structure for responding to unexpected events and related requests for mid-year adjustments. Operational planning is an effective mechanism for exerting authority and control over service initiatives, and a powerful tool for managing hospital operations and expenditures.

Operational planning should be an annual process that translates the hospital's long-range plans, social contract and strategies into specific programs, services and activities for the coming year. The operating plan should take into account fiscal resources and the status of existing programs and services as they relate to the hospital's social contract. Planned changes in programs and services should be based on negotiations with the community, other health and social service agencies, the district health council and the Ministry of Health.

The operating plan should include a statement of the hospital's objectives for the year, and related plans for and estimates of:

- clinical programs and procedures to be introduced, expanded, or enhanced;
- clinical programs and procedures to be contracted or eliminated;
- new clinical staff appointments and departures (an annual clinical human resources plan);
- patient volume in each new or existing patient care program;

- diagnostic and therapeutic services to be introduced or expanded;
- diagnostic and therapeutic services to be contracted or eliminated;
- support and administrative services to be introduced or expanded;
- Support and administrative services to be contracted or eliminated;
- service volume/workload of each diagnostic, therapeutic, support and administrative department/service;
- equipment that will be replaced or added;
- hospital-wide human resource initiatives (for example, pay equity, employment equity, occupational health and safety, WCB, alternate work); and
- departmental, program and hospital-wide management processes that will be introduced.

Internal and External Consultation. Management should ensure that the operational planning process provides all hospital staff with the opportunity to participate. It should allow for staff input into both the initial formation of the plan and its refinement through review and criticism.

Also, the hospital should develop its operating plan in the context of its social contract. The process for developing the annual operating plan should include consultation and, if necessary, collaboration with other organizations providing health care and social services to the hospital's functional communities. The focus of consultation with other providers should be to confirm the continuing relevance of the hospital's social contract and long-range plan, and to identify current responses to the changing health care needs of the community.

The hospital's social contract would be reinforced if the hospital were required to engage in consultation with other providers during the course of preparing the annual operating plan. Changes in programs and services which the hospital was considering for its annual operating plan, and which had not been agreed to in its social contract or not renegotiated, would be in breach of the contract. These program and service

changes which the hospital was considering for that year could have a significant impact on the programs, services and fiscal viability of other providers, and effect the community's access to services. As a matter of policy, every year in the course of preparing annual operating plans, all health care agencies, including hospitals, should review and coordinate their plans to maximize benefits to the community and minimize disruption to each other and to the community. Independent initiatives by hospitals (and other health care agencies) that reduce the community's access to services, or that will have an impact on other providers, should be subject to review.

Before a hospital makes a modest realignment or change to an existing program (for example, reassignment of the psychology department from outpatient to inpatient activity), it should, at a minimum, notify and preferably consult with other providers. More substantial modifications which affect provincial, regional or priority local programs, but do not involve changes to the social contract (for example, reducing the number of cardiovascular surgery cases), should require participation by the Ministry of Health, the district health council and other providers serving the functional community of that program or service. Significant changes to a hospital's programs and services which do affect the social contract (for example, eliminating emergency room services) will likely require renegotiation and reformulation of the contract. To ensure consistency in the way various levels and types of proposed changes are handled, the Ministry of Health should specify the circumstances and processes to be followed when a hospital intends to make changes to its programs or services.

Board Approval. The findings of these collaborative and consultative processes should be assessed by management and an operating plan should be prepared for recommendation to the board. Once the operating plan is developed and approved, it should be filed with the district health council and the Ministry of Health. The plan should clearly communicate, internally to hospital staff and externally to other providers and the community, the initiatives that will be undertaken by the hospital in the coming year.

Recommendations:

We recommend that:

(6.07) The Public Hospitals Act should require hospitals to develop annual operating plans, taking into account their social contracts.

(6.08) The Public Hospitals Act should require hospitals to file their annual operating plans with their local district health councils, or other provincially-mandated body, and the Ministry of Health.

(6.09) The Ministry of Health should specify the roles of the district health council as mediator and the Ministry of Health as arbitrator in dealing with conflict among hospitals and other health agencies with respect to operating plans.

6.3.3 Budgeting and Fiscal Management

The current Act is silent with respect to the budgeting and fiscal management of hospitals. Although the great majority of hospitals provide effective fiscal management, there have been instances wherein hospitals have entered into imprudent financing schemes for enterprises which have been both related and unrelated to the purposes of the hospital.

Operating Budgets. The operating budget of the hospital should be based on the hospital's annual operating plan. The operating plan should define all new initiatives and their implications for patient and service volume. The budgeting process would then determine the fixed and variable cost of each unit of service, accumulate costs within and across departments and compare costs with revenues.

Hospitals should not operate with losses and should not accumulate operating deficits except as part of a financial plan which includes debt repayment. Hospitals must be managed in a way that both meets their obligations under the social contract and, over time, generates operating surpluses or at least a 'break even' cash position.

The hospital's operating budget represents the hospital's financial commitment to the programs and services stipulated in its social contract for a given year, within the five-year framework of the social contract. Each annual operating plan and budget should contain assumptions about the programs and services of the hospital and other providers over the coming years, and about the funding which will be available to support those services and programs. To ensure it can fulfill its responsibilities, the hospital, and other providers, will have to develop multi-year projections of expected revenues and expenditures. Any unexpected changes in the hospital's financing could affect the hospital's services, those other providers and the community's access to services.

Because hospitals receive most of their revenues from the Ministry of Health, the accuracy of these multi-year forecasts would be significantly enhanced were the Ministry to provide multi-year funding arrangements for hospitals. Minimally, the Ministry should provide hospitals with indications of significant changes in funding with sufficient time for them to plan and negotiate changes in services and social contracts. Although not a subject for this review of the Public Hospitals Act, multi-year funding would provide for more effective participation by hospitals in the recommended processes for social contracts and operational planning.

Capital Budgets. Prudent financial management suggests that hospitals should also develop multi-year capital expenditure plans. Cash requirements for capital projects (and in some cases for operations) need to be planned and arrangements for financing need to be made well in advance of actual expenditures.

Hospitals are currently responsible for a significant portion of the capital costs related to construction and renovation of facilities and new equipment. A potentially significant source of funds to support the hospital's share of its capital activity is its operating surplus. The introduction of the Business Oriented New Development Plan (BOND) in 1982, among other things, allowed hospitals to retain their operating surpluses.

Surpluses were to be available for:

- financing future operations,
- improving the hospital's working capital position,
- financing facility renovation and construction, and
- financing the acquisition of new equipment.

However, the BOND position on the use of operating surpluses for capital purposes is potentially inconsistent with legislative practice. The formal definition of a legislative vote considers operating surpluses to be monies that started with a 'vote' for the funding of hospital operations and thus are restricted, by the terms of the vote, to be used for hospital operating costs. This requires that operating surpluses be retained and accumulated to be used only for the purpose of funding new programs and services or potential operating losses in a future year. This suggests that, despite BOND, hospitals cannot use their operating surpluses for capital purposes.

The BOND program also provides for the consolidation of all hospital revenues for ancillary activities - for example, cafeteria, parking lot, office rent, room differentials, workers compensation - with funding from the Ministry of Health. Since all hospital revenues, both Ministry and ancillary, are now co-mingled and used to fund operating costs, it is difficult to determine whether a hospital's surplus funds are from Ministry funding, from ancillary activities or from both. A hospital could argue that the net revenues generated by its ancillary activities - which in some cases exceeds 30% of a hospital's revenues - is responsible for all or part of its operating surplus, and that all the funds from the Ministry were used solely for operations. In such circumstances, it is difficult to expect the intent of the legislative vote to apply.

The current formulation of the vote limits a hospital's flexibility to establish its own spending priorities. We recognize that monies from a 'vote' in the legislature are

restricted to the uses specified in the context of that vote. Nonetheless, 'votes' for grants to hospitals, related to operating expenses, should provide flexibility in the use of these funds, provided that hospitals continue to fulfill the terms of their social contracts, and that the purposes of the expenditures are consistent with these contracts.

The technical inconsistencies among BOND, the definition of the legislative vote and legislative practice should be corrected and the current confusion, regarding the use of surpluses for capital purposes, eliminated. The Public Hospitals Act should clearly provide for the use of hospital operating surpluses for all the purposes originally provided for by the BOND program.

There should be limitations, however, on the creation and use of operating surpluses. Hospitals are part of a network of services responding to the health needs of the community. As participants in this network, hospitals should not be able to reduce either the content or quantity of care in order to generate a surplus for the ultimate purpose of enhancing their physical plant or acquiring additional equipment.

Under the existing Public Hospitals Act, hospitals must obtain the Minister's approval of plans to add buildings or facilities. The scope of projects requiring approval is not defined and, as a result, small renovations require approval. Strict enforcement of this requirement would impede basic maintenance and minor improvements to hospitals' physical plants. In practice, however, most hospitals do not seek Ministry approvals for these minor projects, nor does the Ministry insist on becoming involved. It would be useful to create a more consistent approach by defining the scope of capital projects which do not require Ministry approval.

Recommendations:

We recommend that:

(6.10) The Ministry of Health should define surplus operating funds taking into account the hospital's need to accumulate funds for future operating losses, program development and capital requirements.

(6.11) The Public Hospitals Act should permit hospitals to use surplus operating funds for capital purposes within the context of approved plans.

(6.12) The Public Hospitals Act should prohibit hospitals from cutting services in order to provide enhancements or additions to their facilities, or to acquire additional equipment, unless the service reductions are part of an approved plan.

(6.13) The Public Hospitals Act should permit, within defined thresholds and without further approval from the Ministry of Health, minor modifications to facilities that do not substantially alter services.

Fiscal Management. Government cannot, and does not allow, hospitals to fall into bankruptcy. Because they have effectively become spending agents of the Crown, hospitals should be required to take a prudent approach to financial management.

Several issues are involved. One is that the hospital's fiscal stability and health requires a strong working capital position. Another is that the timing of payments from the Ministry of Health often causes short-term shortfalls in revenues. Hospitals often have to delay financing major maintenance and equipment replacement projects until sufficient cash is generated from depreciation expenses. Also, hospitals may have to finance start-up costs of new programs, services, management processes and research initiatives. To provide hospitals with financial flexibility for service and facility initiatives, and to avoid the necessity of borrowing and paying the related interest expenses, hospitals need to, and should be allowed to, strengthen their working capital position.

Conversely, hospitals should not be allowed to create significant negative working capital positions. They should not be allowed to accumulate operating losses, from either hospital operations or ancillary enterprises, that create negative working funds positions. The start-up costs and potential operating losses of ancillary activities should not be allowed to jeopardize the financial well-being of the hospital. Borrowing for capital activity should not exceed the hospital's ability to service the debt.

Given the pressure on hospitals to raise funds to finance their activities, especially capital activities and research, they need freedom to raise funds. It is in the public interest that hospitals continue to be able to raise these funds through operating surpluses, charitable donations and ancillary activities. Funds from these sources provide hospitals with the flexibility to explore innovative approaches to fulfilling their social contracts.

Hospitals should have the flexibility, within defined thresholds, to enter into financing plans designed to assist in achieving their objectives without prior approval of the Ministry. To reduce the risk of significant financial misadventures, for projects beyond this defined threshold, the government should either participate in evaluating the proposed activity or hold the final approval over the size and nature of the activities proposed by the hospital or its related organization.

Recommendation:

We recommend that:

(6.14) The Public Hospitals Act should permit, within defined thresholds and without further approval by the Ministry of Health, financing plans that do not expose the hospital to risk which jeopardizes its continuing financial viability.

Ancillary Activities. Ancillary activities based upon sound business principles have the potential to enhance the services of the hospital. The appropriate scope of hospital ancillary activity is difficult to define. One approach is to define ancillary activity broadly

and attach strong regulatory controls. Another approach is to relate ancillary activity directly to the service objectives of the hospital. Restricting ancillary activities to those that directly relate to the objectives of the hospital will ensure that hospitals do not venture into activities where they lack expertise, and thus minimize the risk that they will suffer significant losses. This approach would see ancillary activity undertaken only when that activity contributes to the financial position of the hospital and is related to the hospital's pursuit of its health care objectives.

Hospitals should continue to be provided with the opportunity to engage in ancillary activities, but only within the following framework:

- the ancillary activity is consistent with the hospital's service objects as agreed to in its social contract and long-range plan;
- the business case of each ancillary activity in excess of a threshold level (to be defined in Ministry guidelines), is assessed by an independent evaluator selected by and accountable to the Ministry of Health and paid for by the hospital;
- the assessment is satisfactory to the Ministry of Health prior to commencement of the ancillary activity, and includes,
  - an evaluation of the risk of the ancillary activity to the financial well-being of the hospital based upon the probability of adverse events,
  - an evaluation of the magnitude of the impact of adverse event(s) on the financial status of the hospital, and
  - an evaluation of the pricing policies and impact of the ancillary activity on local businesses, to ensure that public sector institutions are not using public funds to compete unfairly with the private sector;
- the project is undertaken through a separate corporation to ensure that liability is limited to that separate corporation, if, in the opinion of the independent evaluator, the activity may threaten the long-term financial viability of the hospital;
- the Ministry of Health is not liable for any costs associated with ancillary activities;

- public disclosure of activities is required of all organizations related to the hospital;
- the Public Hospitals Act specifies minimum disclosure requirements for organizations established by hospitals for the purpose of undertaking ancillary activity;
- the scope of disclosure includes at least financial data, names of officers and directors and the nature of the relationship between the hospital and the related organization;
- generally accepted accounting principles determine whether there is a relationship between a public hospital and another organization, and an organization will be considered related to the hospital when the hospital has the ability to exercise, directly or indirectly, control or significant influence over the operating and financial decisions of the organization, or when the hospital and organization are subject to common control or influence.;
- ancillary activities in excess of a threshold, and operated by a separate corporation, have a regular audit accessible to the public to ensure that all "non-arms length" transactions are reasonable;
- the Ministry of Health has the right to order an independent evaluation of ancillary operations with regard to the consequences of the operation on the functioning of the hospital;
- funding mechanisms take into consideration the economic disparities among regions and constraints some hospitals face in engaging in ancillary activities, and funding ensures equity of access to those services that are, or will be, dependent on funding from ancillary activities.
- ancillary activities involving land or other assets owned by the hospital above a threshold level require an independent evaluation and the approval of the Minister of Health, as does land given as security or leased in the long-term; and
- benefits accruing from an ancillary activity are used for purposes consistent with the hospital's social contract.

In the consideration and operation of any ancillary activity, it is the responsibility of the board to weigh carefully the benefits and risks of the operation, and to respond in a deliberate manner to its responsibility for the fiscal integrity of the hospital.

Recommendation

We recommend that:

(6.15) The Public Hospitals Act should provide the hospital with the flexibility to engage in ancillary activities consistent with the hospital's service objects.

6.3.4 Operations Management

The primary focus of management is providing for and ensuring the effective and efficient provision of patient care. Efficient and effective patient care requires, at a minimum, the acquisition and implementation of effective management processes for:

- organizing and supervising the delivery of hospital services;
- controlling the cost of each unit of labour and material used by each department of the hospital in providing its services or producing its products (cost management);
- measuring, monitoring and controlling the number of units of labour and materials employed in producing departmental services (productivity management);
- measuring, monitoring and controlling the number of units of service from each department utilized in each episode of patient care (utilization management);
- ensuring the appropriateness of each episode of patient care (utilization management);
- measuring, monitoring and controlling the number of episodes of patient care (production management); and
- measuring, monitoring and improving the quality and effectiveness of the services and patient care provided by the hospital (quality management).

To be effective in the execution of its responsibilities, management needs to be able to influence and ultimately manage all aspects of the clinical and non-clinical activities of the hospital.

6.3.5 Reporting to the Board

The board of the hospital bears overall responsibility for the effectiveness of the hospital in meeting its social contract. It is, however, dependent on management to provide it with sufficient information to fulfill this responsibility. Management reporting to the board should provide information related to the following attributes of effectiveness.[1]

- Management Direction: the extent to which the objectives of an organization and its component programs are clear, well integrated and understood, and appropriately reflected in the organization's plans, structure, delegations of authority and decision-making.
- Relevance: the extent to which a program continues to make sense with respect to the problems or conditions to which it is intended to respond.
- Appropriateness: the extent to which the design of a program, or its major components, and the level of effort being made are logical in light of the specific objectives to be achieved.
- Achievement of intended results: the extent to which goals and objectives have been realized.
- Acceptance: the extent to which the constituencies or customers for whom a program is designed judge that program to be satisfactory.
- Secondary Impacts: the extent to which other significant consequences have occurred, either intended or unintended or positive or negative.
- Costs and productivity: the relationship among inputs, costs and outputs.
- Responsiveness: the organization's ability to adapt to changes in such factors as markets, competition, available funding or technology.

Taken from "Effectiveness-Reporting and Auditing in the Public Sector: Summary Report", Canadian Comprehensive Auditing Foundation, Ottawa, Ontario, 1987

- Financial results: the matching of, and the accounting for, revenues and costs and the accounting for and valuation of assets, liabilities.
- Working Environment: the extent to which the organization provides an appropriate work atmosphere for its employees, provides appropriate opportunities for development and achievement and promotes commitment, initiative and safety.
- Protection of Assets: the extent to which important assets - such as sources of supply, valuable property, key personnel, agreements, and important records or information - are safeguarded so that the organization is protected from the danger of losses that could threaten its success, credibility, continuity and perhaps its very existence.
- Monitoring and reporting: the extent to which key matters pertaining to performance and organizational strength are identified, reported, and carefully monitored.

Recommendation:

We recommend that:

(6.16) The Public Hospitals Act should require management to present regular and comprehensive reports which provide the board with sufficient information to enable it to fulfill its responsibilities for the overall effectiveness of the hospital.

6.3.6 Effectiveness Audit

The board of the hospital is accountable to the hospital corporation, the community and other constituencies for the effectiveness of the organization. Together, board and management are accountable for the effectiveness of the organization in responding to the needs of the community through the fulfillment of the terms of the hospital's social contract. Management is responsible for developing and implementing structures and processes which ensure the effective and efficient operation of the hospital in accordance with the direction set by the board.

Most auditing of public hospitals in Ontario is in the form of the traditional 'attest to' audit, where the auditors attest to the corporation's financial statements in terms of their fairness, consistency and conformity with generally accepted accounting principles. The purpose of this audit is to provide members of the hospital corporation with an independent opinion concerning the financial statements of the hospital.

In recent years, however, there have been several experiments in the public sector with extending the concept of the audit to examine the effectiveness of organizations in fulfilling their mandates. In the private sector, where profit is a prime motivator, the effectiveness of an organization and its management can be measured in large part by evaluating the corporation's financial results.

In the public sector, however, financial performance is not sufficient, by itself, to reflect organizational effectiveness. Systems need to be developed to provide hospital corporations and their communities with information to help evaluate the effectiveness of the hospital. The public would be well served if hospitals were to undergo some type of independent audit of their effectiveness as one mechanism in the evaluation of governance and management. Effectiveness auditing would also provide those to whom the management of the hospital is accountable with information to determine whether or not management is fulfilling its responsibility for accountability.

Additionally, the accountability of public hospitals to their communities will be reinforced through effectiveness audits of social contracts. An audit mechanism should be established by which the community can be assured that the hospital is fulfilling the terms of its contract. Similarly, there should be a mechanism by which the community can evaluate how well it, and other health care and social service agencies, are fulfilling their respective commitments under the social contract.

Recommendation:

We recommend that:

(6.17) The Public Hospitals Act should require the board to commission annual audits of the hospital's financial statements and statistical information.

(6.18) The Public Hospitals Act should require the board to commission periodic independent evaluations of the effectiveness of the organization and its compliance with its social contract.

6.4 ORGANIZATIONAL STRUCTURE

6.4.1 Unification of Management

The current perspective of the Public Hospitals Act on hospital management and management processes is limited to the duties of the Administrator and the organizational structure of a hospital's medical staff. In relation to the medical staff, the regulations under the Act require that:

- where there is a Chief of Staff, the Chief of Staff is appointed by the board;
- where there is a Chief of Staff, the Chief of Staff is to be the Chairman of the Medical Advisory Committee;
- where there is no Chief of Staff, the board appoints the Chairman of the Medical Advisory Committee;
- the Medical Advisory Committee reports to the board (through the Chief of Staff or its Chairman) with respect to the practice of medicine in the hospital; and
- the Medical Advisory Committee manages the process for medical appointments and privileges and makes related recommendations directly to the board.

This structure has provided hospital boards with good advice and guidance with respect to the quality of patient care in the hospital, and the clinical implications of operational and capital initiatives. It does not provide, however, for a formal organizational relationship between hospital medical staff and hospital management. Each reports

independently to the board. Hospital employees report to the board through the CEO, and the medical staff report through the Chief of Staff or Chairman of the Medical Advisory Committee. The current structure creates a division in the management processes of the hospital. Management processes related to medical programs, services and care are potentially disjoint from management processes related to hospital services and facilities.

Additionally, under this structure the accountabilities of health professionals employed by the hospital can be unclear. Overall, they are accountable to hospital management, through their department manager, for the performance of their function and the fulfillment of their employment responsibilities. However, when caring for an individual patient, they are accountable to the patient, through the patient's physician, for the selection and delivery of their services. Employees can be put in conflict when the imperative of hospital management and management processes is to control and possibly restrict the utilization of resources, and the patient's physician has not received (or not accepted) the same direction from the medical management of the hospital. These types of separations in management responsibilities and staff accountabilities make it difficult, and in some cases impossible, for management to control and direct the affairs of the hospital.

Another complication in the hospital's relationship with its clinical staff is the jurisdiction of the regulatory body for each profession. All the activities of clinical professionals must be consistent with the obligations of regulated health professionals to their regulatory bodies. The requirements of the regulatory body can be in conflict with either, or both, the directions of the department manager and the direction of the patient's physician. Ultimately, however, the professional must accede to the requirements of the regulatory body with respect to the care of the individual patient.

The current Regulations under the Act do not require medical staff participation in decision-making by management, although such participation does take place in some form in most hospitals. The formal processes and structures provide that the MAC will

comment to the board on the implications for medical practice of management decisions after these decisions are made. This role can lead to conflict between the hospital's medical and administrative management. These conflicts, because there is no established resolution process within management, often have to go before the board, although it should not be required, or expected, to arbitrate these conflicts.

Unifying Management. The contemporary hospital has realized that both clinical and operational decisions should be brought together within a unified set of management processes operating within a unified management structure. The distinction between medical (and other clinical) issues and management issues has become largely artificial. Decisions with respect to medical practice, especially the introduction of new procedures, pharmaceuticals and therapeutic processes, and the utilization of resources in patient care, have significant implications for the operating characteristics and costs of the hospital. Decisions with respect to staffing and supplies of hospital departments can have significant implications for medical practice and access to hospital services. It is critical for the continuing success of the hospital that these types of decisions be brought together within a unified set of management processes. Hospital management cannot be held accountable for the quality, effectiveness, efficiency and cost of hospital operations if medical practice and medical affairs are managed through separate and independent structures and processes.

Also, as hospital care and operations become increasingly more complex and resources are restricted, it is important for medical staff (and all health professionals) to become more aware of, and more involved in, all aspects of hospital management. Hospitals are beginning to examine the efficiency and effectiveness of not only hospital departments, but also medical programs and processes, and the manner in which they integrate departmental services into an episode of care for different types or categories of patients. Clinical staff should be involved not only in the discussion, but also in the decisions that directly affect their clinical practices and the care provided to their patients.

Many Ontario hospitals have already established alternate structures which allow for direct participation of medical staff (and other clinical disciplines) in a unified management process. Because, however, of the current legislation and related regulations, even in these hospitals the bifurcated management structure still exists.

These alternate structures, and even the legislated/regulated structures, work reasonably well when there are good working relationships between management and the medical staff and between the CEO and the Chief of Staff. Under these circumstances, issues can usually be resolved prior to going to the board. Where, however, there is disagreement, the board is forced to arbitrate and assume the role of management in resolving the disagreement and making decisions. This is an inappropriate role for the board.

To discharge its responsibility for the effective and efficient provision of patient care, management will need to establish processes to influence and, ultimately, manage the clinical and non-clinical activities of the hospital. Effective management processes related to clinical activity involve clinical staff and, likely, will resemble those processes currently employed by the hospital Chief of Staff and MAC. These processes should provide guidelines for the appropriate use of hospital resources in patient care, and mechanisms for monitoring actual usage and for ensuring adherence to the guidelines. Except for questions of conduct and competence, and then only with appropriate professional consultation, management should not involve itself directly in clinical decisions regarding the care of an individual patient. Management's only involvement should be to ensure adherence to guidelines. All management processes related to clinical activity must take into account, and be consistent, with the requirements of the regulatory body of that clinical profession.

To be effective, the management of the interaction of clinical and non-clinical activity will require structures and processes that ensure the conjoint participation of clinical and non-clinical staff in the hospital's decision-making processes. Effective conjoint participation will require the unification of hospital management. Unification of

management requires the creation of a single management structure directed by one person. The Public Hospitals Act should promote the creation of a unified management process which involves clinical and non-clinical, staff and which is directed by the CEO.

Recommendations:

We recommend that:

(6.19) The Public Hospitals Act should require hospitals to establish, by resolution or by-law, an organizational structure that promotes accountability, participation and communication.

(6.20) The Public Hospitals Act should require that the chief executive officer be responsible for, and accountable to, the board for all aspects of hospital management, including utilization of clinical resources and quality of clinical services.

6.4.2 Corporate Management Officers

In order for each hospital to be able to respond to its own circumstances, the legislation should not prescribe the organizational structure below the CEO. There are, however, certain structural characteristics and intra-organizational dynamics that should be evident in the management structure of a hospital:

- corporate management officers should not be members of the board; however, they should advise the processes of governance, participate freely in board meetings and support the activities of the board;
- the selection process for corporate officers should provide for participation by relevant stakeholders;
- the CEO is accountable to the board and should be appointed by the board with advice provided by internal and external stakeholders;
- the other corporate management officers are accountable to the CEO and should be appointed by the board upon the recommendation of the CEO, taking into account advice from internal and, as appropriate, external stakeholders; and

the management structures and processes of the hospital should promote participation and communication with the clinical and non-clinical staff of the hospital and other internal and external stakeholders.

Under the proposed structure, the CEO would be accountable to the board for all aspects of hospital management. The Public Hospitals Act should require hospitals to appoint corporate management officers to be responsible, with the CEO, for resource utilization and the quality of care provided by individual professionals. Bylaws must specify the qualifications of these corporate management officers. This will minimize the risk of arbitrary decisions and provide a framework for consultative decision-making. As with all management decisions, ultimate responsibility and authority rests with the CEO.

In most instances, the most appropriate officer to participate in these processes with the CEO will have a clinical background; however, the qualifications of this officer should be defined by individual hospitals, taking into account local needs and conditions, and not be defined by either the Act or the Ministry. The corporate officer function, however, is similar to one of the responsibilities currently assumed by the Chief of Staff in many hospitals.

There is an important distinction between the responsibilities of management for resource utilization and quality of care, as envisaged in the unified management approach, and those responsibilities of the Medical Advisory Committee and Chief of Staff under the current Act and regulations, particularly with respect to patient care. Under the proposed unified management approach, the CEO will be responsible for ensuring the management of resource utilization and quality of care. The responsibility, however, for the actual management of these activities can be delegated to the department chief or equivalent. Management decisions regarding resource utilization and quality of care will impact on the professional practice of the clinical staff of the hospital. In these situations it will be important to ensure that adequate clinical information and consultation have been provided to the decision process and that the process is not arbitrary.

Recommendations:

We recommend that:

(6.21) The Public Hospitals Act should not define the organizational structure of the hospital below the level of the chief executive officer.

(6.22) The Public Hospitals Act should assign the chief executive officer the responsibility for ensuring that the management structure and processes of the hospital promote accountability, participation and communication with professionals, employees and stakeholders.

(6.23) The Public Hospitals Act should require hospitals to establish, through resolution or bylaw, a process for selection of corporate management officers that promotes participation by stakeholders.

(6.24) The Public Hospitals Act should stipulate that the hospital board is responsible for the appointment of the chief executive officer, and for the appointment of other corporate management, upon the recommendation of the chief executive officer.

(6.25) The Public Hospitals Act should require the hospital board to appoint at least one corporate management officer to be responsible with the chief executive officer for resource utilization and the quality of care provided by individual professionals.

(6.26) The Public Hospitals Act should require hospitals to specify in their by-laws the qualifications of the corporate management officers who will be responsible, with the chief executive officer, for resource utilization and quality of care.

6.4.3 Advisory Committees to Management

The Public Hospitals Act should provide for the empowerment of hospital staff in ways that create an equal opportunity for staff to participate effectively in the operations of the hospital. The management processes of the hospital should provide for, and promote,

participation by all staff. Those processes and decisions that affect clinical activity and, potentially, the quality of clinical care should have available to them advice and participation from the clinical staff. Committees of health professionals should be established to provide information and advice to management.

In the future, the health care and clinical processes of hospitals will be the responsibility and concern of a number of health professions. There are now a multiplicity of disciplines that are, and should be, involved in a patient's care in the hospital. As a result, the clinical implications of management decisions require the shared, interactive perspectives of the multiple disciplines practicing in the hospital, either as employees or as professionals with appointments to the hospital's clinical staff. Also, the public has an interest in ensuring that each hospital has a commitment to a multi-disciplined approach to treatment and care, and that this commitment is reflected in management and operational structures and processes.

Advice to the hospital's management processes should be provided through a multi-disciplinary framework. The issues related to these areas of hospital operations are not all clinical, nor should their analysis be limited to clinical perspectives. All hospital staff, not just clinical staff, have a stake in these decisions. All staff should have the opportunity to participate in, and to have their perspective represented on, committees considering clinical and non-clinical aspects of hospital operations. Committees should be established to advise management with respect to:

- Quality Improvement including
  - Quality Assurance,
  - Utilization Management, and
  - Clinical Protocols;
- Pharmacy and Therapeutics;
- Ethics;
- Clinical Records;
- Resource Allocation; and
- Clinical Human Resource Planning;

These multi-discipline committees should be expected to comment on, and suggest improvements to, actions being considered by management. They would also recommend initiatives to be considered by management. The committees may also be delegated responsibility for directing the implementation of a process, service or program, or for managing a process related to their mandates.

The multidisciplined structure needs to be augmented with discipline-specific structures to deal with the clinical supervision of each regulated health profession. Committees should be established within each discipline to deal with clinical supervision matters such as:

- credentialling,
- rules and regulations,
- peer review,
- quality or care, and
- discipline.

These discipline-specific committees would perform credentialling and quality monitoring of their discipline within the hospital. They would report their findings to the relevant department manager or department chief. As requested, these committees would also advise the appropriate chief, manager or corporate officer with respect to rules and regulations for professional practice in the hospital and discipline of individual professionals.

In some instances, there may be an insufficient number of professionals in a discipline for an internal committee. External committees could be created to provide the needed supervision. These external committees could be established by a group of hospitals, by a regulatory body, by an academic institution or by consultants. The principle is that clinicians in the hospital be supervised by members of their own discipline.

Within the context of the unified management structure, the multi-disciplined and discipline-specific committees will ensure that clinical staff have improved access to,

and participation in, the decisions of hospital management, and that clinical staff continue to have primary responsibility for supervising the clinical activity of each health discipline practicing at the hospital.

Recommendations:

We recommend that:

(6.27) **The Public Hospitals Act should require hospitals to establish one or more staff committees to advise management with regard to:**

- **quality improvement;**
  - **utilization management,**
  - **clinical records, and**
  - **quality assurance;**
- **ethics;**
- **clinical protocols;**
- **pharmacy and therapeutics;**
- **resource allocation; and**
- **human resource planning.**

(6.28) **The Public Hospitals Act should require hospitals to establish profession - specific committees to advise management with regard to:**

- **credentials,**
- **quality care,**
- **peer review,**
- **rules and regulations, and**
- **discipline.**

CHAPTER 7 APPOINTMENTS AND PRIVILEGES

7.1 INTRODUCTION

The framework for hospital-professional relationships within the present Public Hospitals Act focuses on the roles and responsibilities of physicians. While there are historical reasons for the current role of the medical profession in hospital affairs, this framework should now be altered to reflect the interdependence, abilities and contributions of all health professions in the delivery of high quality patient care. The Public Hospitals Act, and its related Regulations, should be rewritten to apply a multi-disciplinary and inter-disciplinary health services template.

7.2 PROFESSIONALS' ACCESS TO HOSPITALS

Currently, access to hospital facilities is restricted to the patients of doctors and dentists. In the future, it likely will be appropriate for other regulated health professions to have access to hospital resources on behalf of their patients. Regulated health professionals, who are not employed by the hospital, should be entitled to apply for access to hospital resources without requiring the approval or sponsorship of a member of another regulated health profession. Once granted access, they should be able, independently, to request services for their patients.

The Act should, however, differentiate among degrees of access to hospital resources. Regulated health professionals should be given access to hospital resources for one or more of the following purposes:

- treating outpatients;
- treating inpatients;
- registering out-patients; and
- admitting inpatients.

Regulated health professionals should be able to apply for different degrees of access to different types of hospital resources as appropriate to their scope of practice. This

would range from access to diagnostic facilities for out-patients, to access to resources to treat inpatients (admitted by another professional), to admitting privileges for inpatients.

For example, chiropractors may require access to outpatient diagnostic imaging services. Chiropractic services may also be required as part of the treatment of in-patients admitted by other regulated health professionals. It may be, however, that chiropractors will not need to admit their patients to hospital for chiropractic treatment. Midwives, on the other hand, will need admitting privileges because a midwife's scope of practice is defined as "...the assessment, monitoring and provision of care during normal pregnancy, labour and the post-partum period and conducting spontaneous, normal vaginal deliveries". Since the majority of deliveries in Ontario currently occur in hospitals, the privileges required by midwives, when appointed to the clinical staff of a hospital, will likely include admission, care and discharge.

One test, among many, which might guide the development of criteria for granting access to hospital resources, is whether the hospital, in the role defined by its social contract, is an essential site of practice for the scope of practice of the regulated health professional seeking an appointment and privileges.

Recommendations:

We recommend that:

(7.01) **The Public Hospitals Act should provide regulated health professionals not employed by a hospital with the right to apply for access to the hospital's resources appropriate to their scope of practice.**

(7.02) **The Public Hospitals Act should differentiate among granting access to the hospital's resources for treating outpatients, treating inpatients, registering outpatients and admitting inpatients.**

7.2.1 Appointments, Privileges and Credentialling

The role of a hospital in providing treatment and care to the members of its community is defined by the number and types of health care professionals accessing hospital resources and the nature of their practices. Therefore, the characteristics of the health care professionals holding appointments to the hospital's staff should reflect the hospital's social contract with its community.

Appointments. The term "appointment" should be defined to refer to the statutory and contractual relationship between a regulated health professional, who is not employed by a hospital, and the hospital corporation, whereby that professional is granted access to the hospital's resources.

Privileges. When the regulated health professional, not employed by a hospital, is "appointed" to the clinical staff of the hospital, the specific hospital resources that will be made available are dependent upon the degrees and terms of access (privileges) specified in making the appointment. The term "privileges" should be defined to refer to the degrees of access and the specific procedures, therapies and related resources that can be used, in keeping with the scope of practice of the health professional.

Obligations. It is reasonable for obligations to be imposed on regulated health professionals in return for the privilege of using hospital resources. "Obligations" often include clinical activities, including ward or emergency duty, taking part in hospital committee activities, teaching and research. It is currently the practice in Ontario hospitals to impose such obligations by way of internal management mechanisms, normally through the by-laws of the corporation and the rules and regulations of the medical staff. Although regulated health professionals appointed to hospital staff should respond to organizational requirements for their participation in management and clinical duties, "obligations" as a condition of appointment do not belong in legislation. Current

practice is adequate. It is noted, however, that by defining "appointment" as a contractual relationship, the necessary scope and foundation for the concept of reciprocal obligations is present.

Implementation of this concept will require that both parties be reasonable in their expectations and demands. Professionals must be willing to provide reasonable amounts of time and effort in support of the clinical, management, and educational activities of the hospital. The hospital must also be reasonable in its requirements for participation by its professional staff. Obligations should focus on participation; they must not include sharing of professional fees or payments to the hospital in exchange for, or as a condition of appointment.

Credentialling. The first step in appointing, or employing, a regulated health professional is the process of credentialling. Credentialling involves verifying the qualifications and experiences of regulated health professionals. The only requirement related to credentialling under the current legislation is that the Medical Advisory Committee consider applications and make recommendations to the board for the appointment or reappointment of physicians and dentists. Because of this requirement, hospitals have considerable expertise and experience in credentialling medical staff. This experience will lend itself, with appropriate adjustments, to creating a template for the credentialling process for all regulated health professionals seeking appointment, reappointment and employment with the hospital.

7.2.2 Appointments and Hospital Employees

It follows from the proposed definitions of appointments and privileges that regulated health professionals employed by a hospital would not be "appointed" to the hospital's professional staff. They would be members of staff by virtue of their employment.

The matter, however, is not straightforward. Currently, physicians who are employed by the hospital are also appointed to its medical staff. In effect, physicians in this position

may have a double status, as an employee of the hospital and as an appointed member of staff. This double status may seem inconsistent; and would likely be unworkable if it were extended to all regulated health professionals employed by the hospital. But, it also seems unfair to remove arbitrarily the appointment status, and related statutory rights and protections, of one group of physicians. The Committee was unable to come to a decision on this issue; however, the general, if not unanimous, judgement was that appointments and privileges should be restricted to those regulated health professionals not employed by the hospital.

Given the distinction between those regulated health professionals employed by the hospital and those not employed by that hospital, there necessarily will be a distinction in the process whereby each is granted access to a hospital's resources. Each will enter the hospital's doors through different, but not unequal paths. The paths of engagement should be parallel, the professional requirements equivalent and the process of credentialling equally rigorous for both groups.

Recommendations:

We recommend that:

(7.03) **The Public Hospitals Act should define the term "appointment" to refer to the statutory and contractual relationship between regulated health professionals not employed by the hospital and the hospital corporation whereby those professionals are granted access to the hospital's resources.**

(7.04) **The Public Hospitals Act should define the term "privileges" to refer to the specific procedures and therapies which regulated health professionals not employed by the hospital are entitled to perform in the hospital in keeping with their scope of practice.**

(7.05) **The Public Hospitals Act should prohibit sharing of professional fees with, or payments to, a hospital as a condition of, or in exchange for, an appointment to the hospital staff or specific privileges in the hospital.**

(7.06) **The Public Hospitals Act should require hospitals to establish bylaws and procedures for credentialling of all regulated health professionals seeking appointment, reappointment or employment.**

7.3 MANAGING ACCESS TO HOSPITALS

The distinction between governance and management should pertain to appointments and privileges. It is the responsibility of governance to define the hospital's mission and role and to commit to its social contract. In carrying out these responsibilities, the board will also be defining the hospital's current and future clinical profile; it will be determining, indirectly, the number, types and scopes of service of the health care professionals who should be working in the hospital, and their privileges. Although the board should bear ultimate accountability for appointing and hiring the hospital's clinical staff, it should not be involved in these processes. Responsibility for appointing and employing health professionals should be delegated to management.

Recommendation:

We recommend that:

(7.07) **The Public Hospitals Act should stipulate that the board bears ultimate accountability, operationally delegated to management, for appointments and for the delineation of privileges for regulated health professionals.**

7.3.1 Clinical Human Resources Plan

Management's strategy for achieving the hospital's mission and fulfilling its social contract should include the development and implementation of a clinical human resources plan. This plan should include a strategy for obtaining the types and numbers of health professionals necessary to realize the hospital's desired role. The clinical human resources plan, as with all management decision-making processes, should be developed with the participation of the clinical and non-clinical staff of the hospital, including profession-specific advisory committees and managers of clinical departments.

Recommendation:

We recommend that:

(7.08) The Public Hospitals Act should require the hospital to develop a clinical human resources plan which defines the types, numbers and scopes of service of the regulated health professionals who will be granted access to the hospital's resources to enable the hospital to meet its commitments under its social contract.

7.3.2 Processes for Managing Access to Hospital Resources

Appointments and reappointments of health professionals, and the delineation of privileges, are important functions of a unified management structure. These decisions must be made within the context of the hospital's social contract and related clinical human resources plan. We have recommended that, where numbers warrant, profession-specific advisory committees should be established to advise the hospital's management on appointments, reappointments, privileges, credentials, peer review and discipline; where numbers are insufficient for an internal committee, an external committee, or comparable arrangement, should be established to assist management on these issues.

An application from a regulated health professional for appointment, reappointment or change in privileges would be referred to the appropriate profession-specific advisory committee for consideration. The committee would recommend the disposition of the application to the CEO. In consultation with the designated corporate management officer responsible with the CEO for decisions related to appointments and privileges, the CEO would consider the recommendation and come to a decision. The final decision on whether to appoint the regulated health professional to the clinical staff of the hospital should rest with the CEO, subject to rights of appeal.

Where the profession-specific advisory committee recommends for appointment or reappointment, but the CEO, in consultation with the designated corporate management officer, intends to reject the recommendation, or act differently from the recommendation, the profession-specific committee and the applicant should receive

notification and an explanation. In instances where the profession-specific advisory committee recommends against the application, and the CEO, in consultation with the designated corporate management officer, concurs with the recommendation, the applicant should receive notice of the recommendation of the advisory committee and be entitled to an explanation, if requested. Applicants should also be entitled to make written submissions to the CEO prior to the final management decision.

In instances where the profession-specific advisory committee recommends against the application, but the CEO, in consultation with the designated corporate management officer, intends to make the appointment (or act differently from the recommendation), the profession-specific advisory committee and the board should receive notification and an explanation, and the applicant should receive notification.

These processes do not provide a legislated mechanism to change these decisions of the CEO. If, however, the CEO were to ignore consistently the advice of the profession-specific advisory committees, or make decisions that the board opposed, then presumably the board would replace the CEO.

Participation by Applicants. Applicants for both appointment and reappointment should receive notice of the recommendation of the profession-specific advisory committee, and should be entitled to an explanation of the recommendation, if requested. Applicants should also be entitled to make written submissions to the CEO, and the designated corporate management officer, in support of their applications prior to the final management decision on the recommendation of the advisory committee. Management's decision-making process should provide sufficient time for the applicant to make this submission.

Recommendations:

We recommend that:

(7.09) The Public Hospitals Act should specify that appointments, reappointments and employment be made within the framework of the hospital's social contract and clinical human resources plan.

(7.10) The Public Hospitals Act should specify the procedures to be used by regulated health professionals, not employed by the hospital, to apply for appointments, reappointments and privileges, and to be used by the hospital in responding to these applications.

(7.11) The Public Hospitals Act should stipulate that management is responsible for suspensions and revocations of appointments and modifications of privileges.

7.3.3 Considerations in Making Appointments

Management should consider applications for appointment in the context of the hospital's social contract and related clinical human resource plan. It would be appropriate to decline an individual's application if it were inconsistent with these. Such situations include, but are not limited to, the following:

- the hospital's clinical human resource plan provides for a specified number of appointments and there are no current vacancies among such specified appointments;
- the hospital's clinical human resource plan does not include an appointment for the applicant's health profession; and
- the hospital is financially unable to adhere to the schedule for implementing its clinical human resource plan.

Although the current legislation does not set out this principle, the Hospital Appeal Board (HAB) and the courts have upheld the concept of valid and reasonable human resource grounds for declining initial applications for appointments. The HAB considered the inconsistency of an application for appointment with the hospital's

clinical human resource plan (medical manpower plan) as adequate grounds for rejection. However, an individual whose application was refused on human resource grounds, and who believes that the human resource ground provided by the hospital was unreasonable or not valid, should have an avenue to appeal the issue of reasonableness and validity to the HAB. If, however, the HAB found that the human resource grounds provided were reasonable and valid, the rejection of the initial application would be upheld.

7.3.4 Considerations in Making Reappointments

As the hospital's objectives and plans change over time, management should evaluate the continuing appropriateness of the hospital's social contract, plans and strategies, and the related clinical human resources plan. As part of the reappointment process, the profession-specific committees should advise management on changes in the conditions of appointment or privileges of individual clinicians which have become necessary as a result of changes in the hospital's clinical human resources plan.

Management may then decide to modify the privileges or decline to renew the appointment of a regulated health professional. These types of actions are appropriate if they are based on changes in the clinical human resources plan which are reasonable, which result from necessary and appropriate changes in the hospital's social contract and are not arbitrary or motivated by inappropriate considerations. The appropriateness of these actions is also premised on there being a fair and public process established by the Public Hospitals Act for the development and modification of the hospital's social contract.

Because these types of decisions have a significant impact on the professional's ability to practise and earn a living, reasonable notice of the decision should be provided. One factor, among many, affecting reasonable notice will be the individual's ability to relocate. In some circumstances, it might be difficult for an individual to relocate and,

therefore, reasonable notice could be an extended period of time. Also, each individual whose application for reappointment is rejected, or whose privileges are modified, should have the right to appeal to the board of the hospital or to the Hospital Appeal Board.

Management should also be able to restrict privileges, or not to reappoint, as a result of the incompetence, negligence or misconduct of a regulated health professional not employed by the hospital.

Under the current Act, where an application for annual reappointment is refused for any reason, for any reason, the appointment and privileges continue in effect pending the outcome of an appeal. This should be restated in the new Act.

7.3.5 Considerations in Modifying Privileges in Mid-Term

Under the current Act, a mid-term revocation, suspension or alteration of privileges takes effect immediately and continues in effect pending the outcome of the appeal. In principle, privileges should not be revoked, suspended or altered in mid-term. There may be circumstances, however, when mid-term action is required. In most of these cases, the revocation, suspension or alteration should not take effect until the appeal processes have been exhausted. In very specific circumstances, however, the Public Hospitals Act should provide for immediate implementation of mid-term revocation, suspension or alteration of privileges.

One such circumstances should pertain to questions of conduct arising out of failure to comply with specified hospital bylaws or rules. These bylaws or rules should contain adequate provision for notice and warning, including a notice period. The CEO would review the matter with the designated corporate management officer, arrive at the decision and communicate the notice of modification of privileges, along with the reasons for the decision. The professional would be given a period of time, specified in the hospital's bylaws, to correct the deficiency or to make written submission to the CEO. The professional's appointment and privileges would continue in effect during the

notice period. Failure to correct the deficiency within the time period would result in immediate suspension, in which case the professional would have access to appeal to the hospital board and to the Hospital Appeal Board, or directly to the HAB.

A second circumstance for the mid-term revocation, suspension or alteration of privileges should pertain to questions of competence or conduct where there is clear and compelling evidence of risk of harm to patients. In these instances, the modifications in privileges should take place immediately. The CEO, following the appropriate clinical consultation, would make and communicate the decision to the affected health professional. The processes for such consultation, decision-making and communication should be set out in the hospital's bylaws. The affected health professional should be provided with the reasons for the decision forthwith, and would have the right to appeal to the hospital board and then to the HAB, or directly to the HAB.

Recommendations:

We recommend that:

(7.12) **The Public Hospitals Act should state that a hospital may decline an initial application for appointment on valid and reasonable human resource grounds.**

(7.13) **The Public Hospitals Act should allow a hospital to modify or terminate privileges or decline to renew an appointment on valid and reasonable human resource grounds, with reasonable notice.**

(7.14) **The Public Hospitals Act should stipulate that, with respect to mid-term revocation, suspension or alteration of privileges of a regulated health professional, the privileges in question continue in effect until the appeal process is exhausted, except in two specified circumstances:**

(a) **the failure of the regulated health professional to comply with specified hospital bylaws or rules; or**

(b) there is a question of competence or conduct with clear and compelling risk of harm to patients.

(7.15) The Public Hospitals Act should state that a mid-term revocation, suspension or alteration of privileges related to competence or conduct continues in force pending appeal.

7.4 APPEALS

Decisions regarding access to hospital resources and services are of great importance to regulated health care professionals. Access is a prerequisite for the clinical work of many professionals. In many Ontario communities, the hospital is the only provider of many health care services (e.g., surgery, diagnostic imaging, laboratory, audiology). If they are to practice in these communities, some health care professionals have no choice but to access the hospital. Without access they cannot practice. In almost all instances, access to hospital resources facilitates the clinical activities of regulated health care professionals. Thus, decisions regarding access to hospital resources (usually related to appointments and reappointments, and to modification or suspension of privileges) affect the livelihood and reputations of health professionals.

These decisions, like all decisions affecting the work of employees and independent professionals, should be, and be seen to be, made with uncompromising fairness, due process and regard to natural justice. Health care professionals should be able to appeal hospital decisions regarding access. Appeal processes should be fair to both the professional and to the hospital. The process should be:

- cognizant of the right of patients to safe and effective treatment and care;
- sufficiently protective of the individual, incorporating fairness and due process; and
- sufficiently enabling for the board and management to ensure the fulfillment of the hospital's mission and social contract.

7.4.1 Appeal Processes

Currently physicians and dentists can appeal first to the hospital board, then to the Hospitals Appeal Board (HAB), and finally to Divisional Court regarding hospital decisions related to appointments and privileges. We have reviewed the current processes for appeal and considered their potential application to our recommendations with respect to hospital governance, management and clinical appointments.

Appeals by Employees. The first issue considered was: who should have the right to appeal and to whom? Should employees have the right to appeal management decisions regarding changes in working conditions or employment status? Should appeals be heard by the hospital board, the Hospital Appeal Board, or both? Currently, in most hospitals, those physicians employed by the hospital (mainly in the laboratories) are also considered to be appointed to and members of the medical staff as defined in the current Public Hospitals Act. As members of the medical staff, these physicians currently may have the right to appeal to the Hospital Appeals Board with respect to changes in their working conditions and appointments, and may also be protected by the terms of an employment contract or collective agreement. These employed physicians, because they are members of the medical staff, may also have the right under the current Act to continue working under their prior terms of engagement until they exhaust their rights of appeal.

In considering the issues involved, we were concerned that it would be inequitable for one class of employed regulated health professionals to have access to two avenues of appeal, while other employed health professionals and other staff had access to only one. In the case of employed physicians, the matter is complicated because they already seem to have two avenues of appeal, and it would be unfair to deprive them arbitrarily of one or the other avenue, particularly if the protection afforded them by their employment contracts was less than that afforded by statutory access to the Hospital Appeal Board.

In considering this issue, the Committee was unable to come to a consensus on whether regulated health professionals employed by the hospital should have access to the Hospital Appeal Board. There was agreement, however, that all members of the hospital staff should be treated fairly with respect to their work and working conditions. The hospital should not be allowed to change conditions of employment and privileges, or to terminate employment or revoke an appointment arbitrarily. The processes used to make these changes, and the venues for appeal, might be different for employees and regulated health professionals appointed to but not employed by the hospital, but both should be fair to the individual concerned.

In the future, a growing number of regulated health professionals employed by hospitals will likely be able to admit patients and have independent access to hospital resources. If health professionals employed by hospitals are able to admit patients, it should be understood that they will not necessarily have statutory rights of appeal to the HAB with respect to the alteration of such "privileges". In order to be consistent, however, if health professionals employed by the hospital do not have the right of appeal, they must have recourse in their employment contracts to an appeals process, internal to the organization, when terms and conditions of their employment are substantially altered.

Similarly, where a hospital terminates the employment of an employed regulated health professional, that professional may not have rights of appeal to the HAB. The professional employed by the hospital would, however, have recourse to the terms of the employment contract or collective agreement. The protection provided by the employment contract of the regulated health professional employed by the hospital should be equivalent to the statutory protection afforded to the regulated health professional appointed to, but not employed by, the hospital.

Appeals to the Board. Appeals to the hospital board regarding decisions of what will become the unified management structure of the hospital would seemingly contradict our justification for creating a unified management structure and our interest in the

separation of governance and management. Such appeals would appear to place the board in the position of second-guessing management and resolving disputes between management and regulated health professionals not employed by the hospital.

In the interest of fairness for the health professional involved, however, there should be an avenue to appeal management's decisions regarding appointments and privileges. These decisions are of extreme importance to the long-range plan and social contract of the hospital, the clinical practice of the health professional and, in some instances, the quality of patient care. It would be inappropriate to exclude the board from any role at all in this appeals process, since the board is ultimately accountable for all the activities of the hospital. If, however, management is effective in carrying out its responsibilities, it should be a rare case in which a board would find it appropriate and necessary to reverse a management decision regarding appointments and privileges.

The concept of a committee of the board to deal with appeals is attractive for streamlining the appeals process. Professionals, however, might be concerned with the potential for the CEO and management to influence the selection of such a committee and, therefore, the outcome of the appeal. Having the appeal process at the board level, and making a quorum of the board a requirement for hearing an appeal, should help to alleviate concerns over the influence of hospital management. The number of directors required to hear an appeal will depend on the size of the quorum established in the hospital's by-laws. It should be noted, that the Corporations Act requires a minimum quorum of at least 40 percent of the board.

Recommendation:

We recommend that:

(7.16) The Public Hospitals Act should provide regulated health professionals not employed by the hospital with the right to appeal decisions with respect to their appointments and privileges to a quorum of the hospital board, prior to an appeal to the Hospital Appeal Board.

7.4.2 Grounds for Appeal

It has previously been recommended that hospitals should be able to decline applications for appointment and reappointment, and to modify or restrict privileges on reappointment on valid and reasonable human resource grounds. Regulated health professionals applying for appointment, reappointment or a change in privileges should have a right of appeal to a quorum of the hospital's board of directors where their application has been declined for human resource grounds and the applicant contests whether the specified human resource grounds are valid and reasonable. They should also be entitled to appeal where their application is declined by management for reasons other than valid and reasonable human resource grounds.

Management might also legitimately decide to reject or restrict the privileges of an applicant for reappointment as a result of the professional's incompetence, negligence or misconduct. The professional should have the right to appeal the action and the validity of the grounds for the action.

In instances where privileges are modified or appointments are revoked as part of an application for reappointment, the practitioner's appointment and privileges should continue pending the outcome of an appeal.

Recommendation:

We recommend that:

(7.17) **The Public Hospitals Act should provide a regulated health professional not employed by the hospital with the right to a hearing before a quorum of the hospital board where management rejects an application for appointment, reappointment or modification in privileges for reasons other than valid and reasonable human resource grounds, or where the applicant contests whether such grounds are valid and reasonable.**

7.4.3 Appealing Mid-Term Modifications of Privileges

As has been discussed previously, mid-term revocations, suspensions and modification of privileges should be restricted to questions of competence and conduct. In questions of competence or conduct, where there is clear and compelling risk for patients, the revocation, suspension or alteration should be effective immediately and the health professional should be provided with reasons forthwith. The professional would have two choices:

- request a hearing before the hospital board, this hearing to be held within 14 days of the action, and a further right of appeal to the Hospital Appeal Board; or
- request a hearing before the Hospital Appeal Board, this hearing to be held within 30 days of either the action or the hearing before the hospital board.

In questions of conduct, where the professional is not adhering to specific laws or rules of the hospital, the revocation of an appointment, suspension or modification of privileges would take place only after an appropriate notice period, as set forth in the bylaws of the hospital. The professional could either:

- request a hearing before the hospital board, this hearing to be held within 14 days of the action, with a further right of appeal to the Hospital Appeal Board; or
- request a hearing before the Hospital Appeal Board, this hearing to be held within 30 days of either the action or the hearing before the hospital board.

In all other cases, a health professional should have the right to appeal a mid-term alteration of privileges, and the alteration of privileges should not take effect until all appeal processes have been exhausted.

Recommendation:

We recommend that:

(7.18) The Public Hospitals Act should provide a regulated health professional not employed by the hospital, and subject to a mid-term suspension or alteration of

privileges which takes effect immediately, with the right to choose one of the following routes of appeal: a hearing before a quorum of the hospital board followed by an appeal to the Hospital Appeal Board; or an appeal directly to the Hospital Appeal Board without an initial hearing before a quorum of the hospital board.

7.4.4 Implications of Teaching and Research

The social contract of many hospitals, particularly teaching hospitals, will require them to participate in the education and training of future health professionals, and to conduct health-related research. The social contract of these hospitals will explicitly recognize this commitment. The clinical human resources plans of these hospitals will require clinical staff to demonstrate experience and performance in education and research, as well as in health service.

One mechanism for demonstrating the professional's competence, experience and current activity in education and research is a joint appointment to the staff of both the hospital and of the affiliated academic institution. By this mechanism, the members of the hospital's clinical staff would have to meet the requirements of both the hospital and the affiliated academic institution with respect to their qualifications and performance. In this way, joint appointments would help demonstrate the health professional's competence in clinical service, teaching and research for the purposes of appointment and reappointment to both the hospital and the academic institution.

In the case of teaching hospitals, the appropriate requirements for service, education and research must be taken into account in the application of criteria for appointment, reappointment and termination. These criteria should be one basis for consideration by the Hospital Appeal Board in the event that appointment decisions are appealed to that body.

Recommendation:

We recommend that:

(7.19) The Hospital Appeal Board should recognize that hospitals involved in teaching or research may include qualifications, experience and performance in education and research, as well as in clinical service, in their criteria for appointments and reappointments.

7.4.5 Hospital Appeal Board

Currently, the mandate of the Hospital Appeal Board (HAB) is restricted to physicians and dentists. In the future, all regulated health professionals will be entitled to apply for access to hospital resources, and members of at least several additional health professionals may be appointed to the hospital's professional staff and granted privileges. Thus, the mandate of the HAB should be expanded to include all regulated health professions.

Under current legislation, the membership of the HAB consists of two physicians, one lawyer or judge and two persons representing the public interest, one of whom is a member of a hospital board. The composition of the HAB needs to be expanded to reflect the greater diversity of health professionals who will have appointments and privileges at hospitals. This expansion will also create, beneficially, a larger pool of board members to hear cases. Each HAB panel should include a member of the appellant's profession.

The Act should also provide for pre-hearing conferences as a forum for negotiated settlements of disputes. Under the current legislation, there is a Chair of the HAB, but no Vice-Chair. To facilitate pre-hearing conferences, there should be provision for a Vice-Chair of the HAB to share responsibility for pre-hearings with the Chair. This would move cases through pre-hearings more expeditiously. Where the Chair presides over a pre-hearing settlement conference which does not result in a settlement, the Vice-Chair can preside over the appeal. Conversely, where the Vice-Chair presides over an unsuccessful settlement conference, the Chair would hear the appeal.

Recommendations:

We recommend that:

(7.20) The Public Hospitals Act should expand the mandate of the Hospital Appeal Board to include all regulated health professions.

(7.21) The Public Hospitals Act should expand the size and composition of the Hospital Appeal Board to reflect the range of regulated health professionals with hospital appointments and to provide for a larger pool of members to hear cases.

(7.22) The Public Hospitals Act should stipulate that each panel of the Hospital Appeal Board hearing an appeal by a regulated health professional must include at least one member of the appellant's profession.

(7.23) The Public Hospitals Act should provide for mandatory pre-hearing settlement conferences for appeals to the Hospital Appeal Board.

(7.24) The Public Hospitals Act should provide for the appointment of a Vice-Chair of the Hospital Appeal Board to facilitate pre-hearing settlement conferences.

7.5 INTERDISCIPLINARY PATIENT CARE

Granting health care professionals, other than physicians, access to hospital resources will require substantive and substantial modification of current hospital practices, such, as written orders, practice protocols, clinical records and requests for consultations. The success of this initiative to grant other disciplines access to hospitals will depend ultimately upon the extent to which dealings among regulated health professionals in the hospital are marked by mutual respect and inter-disciplinary collegiality. The processes for making appointments, granting privileges and credentialling will need to ensure consistency in staff qualifications sufficient to build trust and respect among the clinical staff of the hospital.

Ensuring the quality, continuity and safety of the treatment and care provided to the patient is of primary importance. This will require that one caregiver have primary responsibility for the patient and be accountable for the direction of that patient's treatment and care. The scope of practice of each practitioner, and the requirements and desires of each patient, should guide the selection of their primary caregiver. It is anticipated that, in a multi and inter-disciplinary context, collegial relationships among professionals will result naturally in appropriate selection criteria and procedures for determination of the primary care giver. The board, however, should ensure that policies and procedures are established for the designation of the primary caregiver, and for the transfer of that designation from time to time as required by the changing condition of the patient. The requirement that a single professional be responsible for the overall care of the patient should not preclude appropriate consultations with other health professionals. Also, other health professionals should be required to respond to appropriate requests for consultation.

Recommendation:

We recommend that:

(7.25) The Public Hospitals Act should require that only one professional is designated as having sole, overall responsibility for any one patient.

7.6 RELATIONS WITH PROFESSIONAL BODIES

Health professionals working in hospitals are accountable to both the hospital and to their professional governing body or college. It is in the public interest for hospitals and the various governing bodies to keep each other informed of issues of importance with respect to individual practitioners. This will assist each in ensuring the quality of health services provided to the public.

Although there is agreement among Committee members on the need for regulatory bodies and hospitals to keep each other informed, there are differing perspectives on the type of information that should be shared. One argument suggests that the public interest is best served if regulatory bodies and hospitals share information at the time

that a practice or conduct action is initiated against a professional. This would ensure that the hospital and the regulatory body are aware of a potential problem in a timely fashion. It would also allow the regulatory body and others to develop inferences from patterns of actions against a professional and initiate independent investigations, as appropriate.

A competing argument is that, although the public interest might be served, it would be unfair to the professional to broadcast actions before they are concluded. This could unfairly and unjustifiably affect the confidence of patients and peers in the professional's conduct and competence and possibly affect the professional's ability to earn a living, even if the action against the professional failed. After considering the arguments, the Committee decided that only concluded actions should be communicated among hospitals and regulatory bodies.

Credentialling must be a rigorous and thorough process wherein all pertinent information is readily available to the hospital. When requested by a hospital, in support of its credentialling of applicants, the governing bodies for health professionals should be required to provide all the information available to them regarding negatively concluded privilege, malpractice, and professional misconduct actions. Hospitals should be required to consult the appropriate governing body as part of their credentialling process. Also, the governing body should be required to notify a hospital automatically when proceedings are concluded, and a finding of professional misconduct is made against a regulated health professional on staff at that hospital.

Similarly, hospitals should be required to notify the appropriate governing body regarding all negatively concluded hospital appointment or privilege actions regarding the competence or conduct of regulated health professionals. This will assist the governing body in advising other health agencies regarding the qualifications and experience of health professionals. To facilitate these notifications, hospitals should be required to inform the relevant governing bodies of the professionals they have appointed or employed in their facility.

Recommendation:

We recommend that:

(7.26) The Ministry of Health should develop mechanisms to facilitate the timely and appropriate exchange of information between hospitals and governing bodies regarding the continuing competence and professional conduct of individual regulated health professionals.

7.7 HOSPITAL LIABILITY

Currently, hospitals are vicariously liable for the negligence of their employees, but they are not vicariously liable for the negligence of independent contractors such as self-employed physicians and dentists. Hospitals, however, are responsible for competently performing the credentialling function, and for monitoring the performance of their independent health professionals during the term of their appointments.

Concurrent with this review of the Public Hospitals Act, J. Robert Prichard, acting on behalf of the Conference of Deputy Ministers of Health, conducted a landmark review of liability and compensation matters associated with health care provided by professionals, institutions, voluntary organizations and the Canadian Blood Supply System. We have reviewed this study and endorse its recommendations related to hospital liability for the actions of its non-employee physicians (and other non-employee health professionals).

Recommendations:

We recommend that:

(7.27) The Public Hospitals Act should allow doctrines regarding vicarious liability, and the responsibility of health care institutions for the torts of their non-employee health professionals, to be developed through case law.

CHAPTER 8.0 QUALITY

8.1 INTRODUCTION

Quality is a major concern of the hospital. In our consideration of issues related to the quality of hospital care and services, we have sought to review and understand quality concepts; suggest strategic directions for achieving high quality in hospitals; and recommend how quality can be managed and improved through legislative provisions, hospital governance, management action, professional practice and government support. We have not attempted to define specific standards, review measurement techniques or recommend control mechanisms related to the quality of hospital care and services. These change rapidly and it would be unrealistic to attempt to set out an approved method or methods.

8.1.1 Definition of Quality

Quality is the degree of excellence achieved in performing a function, providing a service or producing a product. The quality of hospital care and services can be viewed from many perspectives.

From the patient's perspective, quality is related to considerations such as the ease of access to treatment and care, the skill of and the care provided by the health professionals, the outcome of treatment, the taste of the meals, the cleanliness of the rooms and the respect shown to the patient by each member of the staff.

From the clinical perspective, quality means excellence as demonstrated by the appropriateness of diagnostic and therapeutic procedures, the accuracy of diagnosis, the efficacy of treatment, and the outcome. Excellence includes the absence of inappropriate services that do not contribute to the patient's well-being or that may be harmful, and in both cases, waste the hospital's and the community's resources.

From the institutional perspective, quality is concerned with the effectiveness of treatment, the cost-effective use of resources in the provision of care, the efficiency of clinical, administrative and support services and the responsiveness of the organization to the needs of its community. To society at large, quality is often considered to be the value and benefits received by the community relative to the cost of health care.

Quality, therefore, should be broadly defined to encompass the multiple dimensions of clinical effectiveness, patient safety and satisfaction, efficiency and value for money. A hospital's quality efforts should be focussed on continuously improving performance in all these dimensions.

8.1.2 Current Quality Related Activities

Hospitals carry out many activities designed to measure, monitor, maintain and improve the quality of hospital services and care. Each is focused on particular dimensions of quality. The current activities include:

- Risk Management,
- Inspection, Investigation, Disciplinary Action,
- Licensing, Accreditation and Standards and Guidelines,
- Utilization Reviews, Outcome Reviews, Peer Comparisons, and
- Quality Assurance.

Risk Management

Risk management is concerned with protecting the hospital against financial losses due to failures in addressing potential and actual risk to the safety and well-being of patients and hospital staff. The focus of risk management is not the quality of patient care and services but the identification and elimination of risks and the prevention of medical-legal liabilities.

Inspection, Investigation, Disciplinary Action

These regulatory activities address the question: "What has gone wrong and who is at fault?" Current legislation related to quality in hospitals is directed almost exclusively to providing regulatory bodies with the power to inspect and investigate, to enforce corrective and disciplinary actions and to suspend the license to provide care. The primary objective of such activities is to protect the public from gross negligence and incompetence, not quality improvement. These activities are necessary and should be continued but they should not be equated with quality improvement activities.

Licensing and Accreditation

These quality control activities address the question:" Did we meet the standards set by experts?" These activities measure and compare the performance of individuals and organizations against external standards. The objective is to distinguish deviations from generally recognized and minimally acceptable standards of practice. These activities will alert providers to serious quality problems and may help prevent a hospital from failing to meet normal operating standards. They do not, however, provide processes to improve performance or to correct persistent problems which may exist as part of a hospital's normal operations. Because of the nature of these reviews, they tend to look at structural and process characteristics of hospitals. Current techniques do not provide for evaluation of outcomes.

Utilization Review, Outcome Review and Peer Comparisons

These activities address the question: "Who is performing differently from accepted patterns of practice". These activities provide for the identification of deviant and potentially deficient and/or inordinately expensive practices of individual health care providers. Currently, these quality review activities are carried out primarily by physicians looking at the practice patterns of other physicians. These processes provide a reasonable level of review of clinical practice, However, there is a reluctance, except in extreme cases, to introduce corrective action because they focus on individual practitioners. In more recent years, medical-legal concerns have led clinicians to become concerned about even participating in these activities.

Quality Assurance

These activities attempt to maintain predefined levels of quality. The responsibility for quality assurance is usually assigned to professionals who work with health care providers to measure performance, to ensure that performance levels meet specifications, and to take preventive or corrective actions when they do not.

Quality assurance is concerned with the improvement of quality. However, there are many hospitals where quality assurance is regarded as a specialized staff function rather than as an integral part of the hospital's processes for the delivery of care and services. In these cases, quality assurance programs are only able to influence discrete segments of hospital care and services. They are often too limited in scope to produce significant improvements across all facets of the hospital and thus impact on the overall quality of hospital care and services. The major deficit of most quality assurance functions is that they are too narrowly focused. They are unable to create organization-wide commitments to quality in all its dimensions, or to foster processes for the continual improvement of quality.

Adequacy of Current Quality Activities

Although the goal of current quality improvement activity is the improvement of the quality of hospital care and services, hospital have often not been effective in making quality a part of the culture of the organization or in continually improving the quality of their care. Most current quality activity focuses on reduction of liability, the protection of the public, setting of standards and practice guidelines, measurement of performance, and resolution of problems.

Current activities also fail to recognize that there are few proven absolute standards for health care quality. Rapid advances in medical knowledge and technology, changes in social, political and economic conditions, and rising public expectations mean that quality will remain a moving target. Efforts to improve quality must be a continuous and dynamic process of striving towards ever-better performance.

8.2 QUALITY IMPROVEMENT

While the concept of continuous quality improvement is relatively new in the field of health care, it has been developed and used successfully in manufacturing and service industries for many decades. A distinct quality management philosophy and an array of quality improvement methods and tools have evolved. These concepts and tools, generally known under the umbrella term of "total quality management "(TQM) or "continuous quality improvement" (CQI), are increasingly being adopted and applied in hospitals. The objective is to create an organizational culture committed to striving for excellence and to improving, continuously, the quality of its services and products.

8.2.1 Continuous Quality Improvement

In contrast to traditional quality efforts , CQI or TQM addresses the question: "How can we do better?" In the business world, successful companies have found that the resolve to do better must begin with commitment and leadership from the organization's senior management. Quality efforts are not add-ons, but are built into the organization's strategic business plan and its day-to-day operations. These companies have also found that the causes of deficient quality are usually not a problem employee, but are caused by the systems and processes in which the employee has to function. The way to improve quality is, therefore, not to blame the employee, but to improve the organization's systems and work processes. The CQI approach to quality is a positive one. Problems are viewed as opportunities for improvement, and employees are empowered, given the information, training and skills, to do their jobs properly and rewarded for identifying and acting on opportunities for quality improvements. A "quality ethic" becomes part of the culture of the organization. All staff are instilled with a commitment to quality and this commitment pervades all the activities of the organization. Many organizations, by following this approach to quality, have found that they have been able to improve the quality of their products and services, and at the same time increase output and reduce costs.

8.2.2 Application of CQI to Health Care

There is increasing evidence that the principles of CQI can be adapted for use in health care. Two examples are the U.S. National Demonstration Project and the Joint Commission on Accreditation of Healthcare Organizations.

The National Demonstration Project began in September 1987 as an experiment in the application of modern quality management to health care. One phase of the project brought together 21 experts in quality management from U.S. industry with 21 American health care organizations, and applied their expertise and tools to make quality improvements in the health care organizations. The experiment showed good success in improving operational processes (e.g., billing, information transfer, equipment maintenance) and service processes (e.g., telephone access, appointments, patient transfers, patient discharges). Few of the projects involved clinical processes or professional staff; nevertheless, the principal investigators were of the opinion that quality management, in principle, can be used to improve clinical processes, such as physician decision-making, diagnostic strategies and medical treatments.

The Joint Commission on Accreditation of Healthcare Organizations has recently adopted a set of 11 principles of "Organization and Management Effectiveness" as part of its major initiative, the Agenda for Change. These principles emphasize total organizational commitment to continuous improvement in quality of care. This commitment must become a part of the culture of the Ontario public hospital and must shape the daily activities of all staff and other participants in hospital activities.

Several hospitals in Ontario have begun to implement quality management concepts and techniques. The initial results from these hospitals are encouraging. More health care providers and managers are coming to believe that the theoretical and practical tools of modern quality management can be applied successfully to both the clinical and non-clinical components of the hospital setting.

Hospitals can learn from the experience of the private sector. The first move is for health care providers and managers to shift their quality efforts from a focus on after-the-fact inspection and audit to a focus on continuous improvement in all clinical, support, managerial and governance functions.

Hospitals can no longer rely solely on external interventions such as inspections, accreditation, and the measurement of performance and outcome against set standards to fulfil their responsibilities for quality. Hospitals must look within their own organizations to seek out, actively and continuously, new and better ways of providing patient treatment and care. This will require continuing efforts to improve the determinants of patient care including the effectiveness and quality of diagnostic and therapeutic services; the efficiency and quality of support and administrative services; the appropriateness of the utilization of hospital services, materials and facilities; and the overall effectiveness of the management of the organization.

Hospitals should shift the focus of their quality activities to a continuous, proactive process of quality improvement to produce better results in clinical effectiveness, service quality, patient satisfaction, safety, organizational efficiency and value for money. The Public Hospitals Act and its regulations should facilitate the introduction of these quality improvement processes.

8.3 ROLES AND RESPONSIBILITIES FOR QUALITY IMPROVEMENTS

The roles and responsibilities of the major stakeholders in the quality of hospital care and services need to be spelled out clearly in hospital by-laws in accordance with a framework established through legislation.

8.3.1 Role of Legislation

The dynamics of how quality can be achieved in a hospital will vary from hospital to hospital, depending on its characteristics; and will also vary over time as old approaches are improved and new approaches developed. Quality improvement will always be a moving target. The role of legislation in quality improvement, therefore,

should be one of empowerment rather than the prescription of any specific clinical or non-clinical quality improvement approach or measures.

Legislative provisions with respect to quality should be limited to making quality a responsibility of the board; making quality maintenance and improvement a mandatory activity of the hospital; and to introducing of measures which would support the principles of quality improvement.

The pursuit of continuous quality improvement represents a major shift from current quality efforts in most hospitals. To make this shift, hospital leadership -the board and its senior management - must be actively involved in setting the direction, designing the systems and mobilizing the entire organization to assume responsibility for quality improvement.

The board should foster an organizational culture that promotes and supports commitment to the continuous improvement of the quality of care and services provided by the hospital. The commitment to continuous quality improvement should be incorporated into the hospital's mission statement. Appropriate committee structures, both at the board level and at the operational level, should be created to set strategic directions for and to manage the quality improvement efforts of the hospital. The board should establish by-laws to ensure that all hospital staff and employees are involved in maintaining and continuously improving the quality of care and services of the hospital.

Hospitals are accountable to the patient and the community for the quality of the care and services provided and for quality improvement. Hospitals should fulfil their accountability for quality by publishing annual reports on quality and quality improvement activities and by undergoing periodic external review by an independent third party. The Ministry of Health should prepare guidelines for the focus, content, process and timing of these reviews.

Recommendations

We recommend that:

(8.01) The Public Hospitals Act should require hospitals to strive continuously to improve the quality and effectiveness of hospital services and care.

(8.02) The Public Hospitals Act should provide for the development of Regulations with respect to:

(a) measures to support quality improvement processes in the hospital;

(b) hospital data to be collected and reported; and

(c) annual reports by the hospital submitted to the Ministry of Health and to the public on quality improvement activities and quality of services and care.

(8.03) The Public Hospitals Act should require hospitals to undergo periodic external review.

8.3.2 Quality Committees

A committee responsible for the overall quality of hospital care and services should be set up at the hospital board level. At the operational level, a parallel committee responsible for quality improvement should be established to report to management.

Quality of Care Committee. The recommendation to establish a Quality of Care Committee (QCC) at the board level is in keeping with the principle that the hospital's governing body has ultimate responsibility for the quality of patient care and services. The board, therefore, must be closely and actively involved in monitoring both the quality of hospital care and services and the hospital's quality improvement activities.

The Quality of Care Committee's responsibilities would be:

- to review the hospital's structures and processes for maintaining and continuously improving quality, and to monitor the effectiveness of such structures and processes;

- to review and advise the board on the quality management plans submitted by hospital management; and
- to review reports from hospital management on quality, and quality improvement activities and to advise the board on the adequacy of the hospital's quality improvement efforts.

Since patient satisfaction is a key element in quality improvement, the hospital board should ensure that there is a visible and accessible contact point for patient service to provide information and to receive and resolve complaints. The Quality of Care Committee should include representation from the Patient Services Function to underscore the importance of patient service and satisfaction.

Quality Improvement Committee (QIC). While it is the Board's responsibility to ensure that there are quality structures and processes in place, it is the responsibility of senior management to establish these structures and manage these processes. There should be a Quality Improvement Committee (QIC) at the senior management level. This would be a multidisciplinary committee drawn from both clinical and non-clinical hospital patient care and support services staff, and it would report to the CEO. The Quality Improvement Committee's responsibilities would be to:

- set priorities and formulate annual plans for quality management activities;
- coordinate quality improvement activities throughout the hospital;
- provide financial, technical and human resources in support of quality improvement activities;
- provide training, education, and technical assistance in quality improvement theory and methods to hospital personnel;
- manage, monitor and evaluate quality improvement projects; and
- collect performance data and report on results.

Depending on the size of the hospital, the QIC would serve as the umbrella structure under which subcommittees could be set up, to oversee different types of quality efforts, such as utilization review, quality assurance, clinical protocols, infection control and tissue audit.

8.3.3 Staff Commitment to Quality

Quality improvement will only be successful if it becomes part of the hospital culture. The success of continuous quality improvement is dependent on the combined efforts of all hospital personnel. This requires a major on-going commitment by both the board and senior management, extending through all levels of management and staff. Senior management can guide the process, but the engine of CQI is staff commitment, from cleaners to surgeons. Hospital by-laws should state clearly that it is the responsibility of every hospital staff member and employee to act on opportunities to remove quality barriers and improve the quality of hospital care and services.

8.4 FACILITATING QUALITY IMPROVEMENT

Commitment to quality can only be nurtured, promoted and supported; it cannot be mandated by legislation or bylaws. It is, therefore, important for health care leaders and decision makers to create the right climate and to make the processes, methodologies and data necessary to support quality improvement easily available to the hospital board and senior management who are accountable for quality.

8.4.1 Availability of Data

Activities directed at identifying opportunities to improve quality require the availability of accurate and appropriate data. Hospitals, health care practitioners and other hospital employees have a responsibility to collect the data necessary for identifying the factors most likely to affect the quality of services and care provided by the organization.

Similarly, if quality of care is to be improved, professionals must be given access to those data which will enable them to make continuous improvements. These are data that will allow them to track changes and associated consequences over time. These data are only available in the health records of hospital patients.

No legislation exists which provides professionals with access to health records of patients for the review and improvement of the quality of hospital care and services. The Krever Report recommended limitations on confidentiality of patient records that would allow access to health records to those staff members of a hospital carrying out quality review and improvement activities. The Public Hospitals Act should permit access to health records, without patient consent, to those hospital staff members whose access has been specifically approved by the board for the purpose of improving the quality of care and services.

From a health care system perspective, it is also important that data collected by individual hospitals be compatible so that multi-centred studies and cross-institutional comparisons can be carried out. Although this does not fall within the jurisdiction of the Steering Committee, we stress that steps should be taken to continue and strengthen the policy that hospitals provide the Hospital Medical Records Institute (HMRI) with accurate and timely data related to clinical interventions, resource consumption and the outcome of care. Similarly, HMRI should be encouraged to develop further its intra-hospital and inter-hospital comparative measures of hospital performance with respect to clinical effectiveness and organizational efficiency.

Recommendations

We recommend that:

(8.04) The Public Hospitals Act should provide for access to patients' health records by hospital staff designated by the board to be responsible for quality improvement, and limit their access to that purpose only.

8.4.2 Protection of Quality Improvement Activities

Health care professionals have become increasingly reluctant to participate in hospital quality assurance activities because their participation, and the records of these proceedings, are not protected from being called as evidence in legal proceedings. Also, health care professionals are not protected from legal liability for their participation in these activities.

No meaningful quality activities will be carried out in the hospital unless participants, proceedings and records of quality review and improvement activities are given evidentiary protection. Five provinces - British Columbia, Manitoba, Alberta, New Brunswick and Nova Scotia - have already amended their legislations to provide such protection. Evidentiary protection in these provinces is restricted to participants, proceedings and records of designated committees. Evidentiary protection is also recommended by the Prichard Report on Liability and Compensation Issues in Health Care.

One option is to expand Prichard's evidentiary protection recommendations to cover all documentation and information related to quality review and improvement activities, and to all persons who participate in such activities at large; rather than to restricting protection to participants, documentation and proceedings of a designated committee, such as the Quality Improvement Committee. However, the Prichard Report emphasized the importance of circumscribing the materials or proceedings that are subject to protection, so that the privilege does not interfere with the "access to justice interests of individual patients".

The right balance between evidentiary protection and individual patient rights to information can be achieved by restricting such protection to the Quality Improvement Committee and its activities. All records and proceedings of a hospital's Quality Improvement Committee, including reports prepared for the QIC and statements made at QIC meetings, should be inadmissible in legal proceedings.

Participants in a hospital's QIC activities should also be immune from testifying in court in connection with any aspect of that committee's quality review and improvement activities. They should be immune from being called to court in connection with their membership or participation in the QIC. This, however, should not preclude them from being called because of other positions that they might hold in the hospital, or because of their activities outside of the hospital. Evidentiary protection should not apply to patient records, or other extant data used to develop reports for the QIC, it should apply only to the analysis and the reports themselves.

Also, Section 10 of the existing Public Hospitals Act should be expanded to provide those participating in quality improvement activities with protection from liability. Section 10 states that "No member of a committee of the medical staff of a hospital or of the board or Appeal Board or of the staff thereof and no witness in a proceeding or investigation before such committee or board is liable for anything done or said in good faith in the course of a meeting, proceeding, investigation or other business of the committee or board". Persons participating in QIC activities, together with members of the QIC and its staff, should also be protected from liability for actions taken and statements made in good faith in the course of their participation.

Recommendations

We recommend that:

(8.05) The Public Hospitals Act should make all records and proceedings of a hospital's Quality Improvement Committee, including analyses and reports prepared for the committee and statements made at committee meetings, inadmissible in legal proceedings.

(8.06) The Public Hospitals Act should provide all persons participating in the activities of a hospital's Quality Improvement Committee or Quality of Care Committee with immunity from testifying in court in connection with any aspect of the quality improvement activities of these committees.

(8.07) The Public Hospitals Act should provide all persons participating in the activities of the Quality Improvement Committee or Quality of Care Committee, including committee staff, with protection from liability for actions taken and statements made in good faith in the course of their participation.

8.4.3 Separation of Quality Improvement and "Policing" Functions

The principle of confidentiality of quality improvement processes should also apply within the hospital. The hospital should separate quality improvement activities from "policing" activities, by not allowing the use of quality improvement documentation and records in investigations, credentialling and disciplinary actions.

A significant question is whether or not action should be taken when, in the course of their quality improvement activities, participants in such activities come across indications that professional performance may not meet accepted standards of practice. In the Regulated Health Professions Act (RHPA), analogous provisions which apply to quality assurance activities of professional colleges. To be consistent with the resolution of this issue in RHPA, only the name of the person and practice in question should be brought to the attention of the appropriate authority designated by the board. Although the basic hospital data would be available to management, the quality improvement analysis of these data and the related documentation and reports should not be disclosed.

Recommendation

We recommend that:

(8.08) The Public Hospitals Act should stipulate that proceedings and records of quality improvement activities, undertaken by or for a hospital's Quality Improvement Committee, be treated as confidential information and not used in investigations, credentialling or disciplinary actions.

8.5 ABUSIVE BEHAVIOUR

The patient care processes of hospitals should contain safeguards against abuse of patients. Similarly, the management processes of hospitals should have safeguards against the abuse of staff. Issues of sexual, physical and emotional abuse should be addressed clearly and firmly. There should be safeguards against abuse by staff of patients, by staff of staff, by patients of patients and by patients of staff. Not infrequently, one type of abuse leads to another.

Although it is difficult to develop a comprehensive definition of abuse, it is important that provincial guidelines be established which are well understood by hospital. Each hospital should have policies, programs and mechanisms to deal with abuse, and to provide staff and patients with direction and support in times of difficulty and stress. In preparing these, the hospital board and management should look to its Professional, Employee and Community Advisory Council and Patient Services Function for advice. The behaviour of staff to patients, and to each other, is a manifestation of the culture, ethics and values of the hospital. To the extent that these are positive, mutually reinforcing, permeate the institution and motivate those within it, the opportunities and incentives for abusive behaviour will diminish.

Recommendation:

(8.09) The Public Hospitals Act should require hospitals to establish policies and procedures for dealing with abusive behaviour.

CHAPTER 9 THE PATIENT

9.1 INTRODUCTION

The well being of the patient is the primary purpose of the hospital. The status of the patient needs to be addressed within the broader thrust of the hospital's commitments to patient care, continuous quality improvement, community responsiveness and ethical orientation. The current Public Hospitals Act should reflect recent developments in common law and legislative initiatives which affect patient's rights and the hospital's obligations to the patient concerning choice and informed consent, confidentiality and advocacy.

Issues of patient status involve three concepts: empowerment, partnership and participation. One of the aims of health care reform articulated by the Premier's Health Council on Health Strategy (1990) is that "citizens and consumers will be empowered to achieve health". Empowerment means enabling patients to obtain the necessary resources to which they are entitled, such as access to information and to play an effective and appropriate role in the hospital's decision making affecting them. Partnership means that those who work in the hospital and those who use its services cooperate and collaborate based on specified rights, responsibilities and accountabilities. Participation conveys the commitment to involve staff and patients and their supporters according to their collective aims and individual needs, as well as according to their titles and functions.

Empowerment, partnership and participation reflect a vision of the hospital in which all the partners have legitimate interests in the operation of the hospital and a share in striving toward the best results for the patient. One of the purposes of the new Public Hospitals Act should be to give practical effect to these concepts at the level of the patient as well as of the community.

9.2 PATIENT RIGHTS

A number of patient rights already exist in legislation or can be extrapolated from The Canadian Charter of Human Rights and Freedoms and common law. Some of these rights are not as well defined or as comprehensive as they need to be. The provincial government has undertaken a number of legislative initiatives to resolve the various issues in a comprehensive and consistent way. In the light of these provincial initiatives, which the Steering Committee endorses, there is no advantage to attempting to recast patient rights within the more narrow context of The Public Hospitals Act, except where these initiatives may fail or be incomplete.

9.2.1 Choice and Informed Consent

For some years, there was no legislation that dealt exclusively and comprehensively with the many issues pertaining to patient consent to health services. The consent provisions in the Mental Health Act, the Child and Family Services Act and the Regulations under the current Public Hospitals Act apply only to the settings and services specified in these individual Acts and Regulations, and they are not consistent with each other. The issues, which are complex and far reaching, involve consent to health services by mentally competent patients and consent on behalf of mentally incompetent persons.

In common law, the courts have elaborated criteria for determining the existence of informed consent:

1. The health care provider has an obligation to provide the patient with all the information about the nature and consequences of the intended health service to allow the patient to arrive at a reasoned decision;

2. The patient must be mentally competent, that is, to have the ability to understand and appreciate the nature and consequences of the health service;

3. Consent must be freely given;

4. Consent must not be obtained through misrepresentation or fraud;

5. While consent may be tacit or implied, express instructions override any implied consent;

6. An individual cannot consent to the performance of an illegal health service;

7. Consent must be in relation to the health service actually performed, unless the patient's life or health is immediately endangered and it is impracticable to obtain the patient's consent.

The legislative initiatives to deal with the issues around consent include Bill 108, the Substitute Decisions Act (1991) led by the Ministry of the Attorney General and Bill 109, the Consent to Treatment Act 1991, led by the Ministry of Health; Bill 108, The Substitute Decisions Act, 1991. Under Bill 110, the Consent and Capacity Statute Law Amendment Act, 1991, the Mental Incompetency Act will be repealed and related statutes amended to make them consistent with Bill 108 and Bill 109.[1]

The specific elements of Bill 109, Consent to Treatment Act, 1991, include the following:

- applies to all regulated health care professionals, to all health services and in all health settings;
- codifies the common law rules of consent; consent must be obtained by a regulated health professional from a mentally capable person, consent must be informed and consent must be given voluntarily;
- specifies that, to give informed consent, the person, before giving it, must have received all the information about the treatment, alternative courses of action and the material effects, risks and side effects in each case that a reasonable person

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[1] At the time of writing, these Bills have received second reading and are before the Standing Committee on Justice.

in the same circumstances would require in order to make a decision;

- establishes a presumption of capacity to be 16 years of age;
- permits the regulated health care professional to determine the mental capacity of the patient;
- provides for a review and appeal process;
- lists those individuals who can act as substitute decision makers;
- establishes criteria for the making of decisions on behalf of incapable persons;
- provides for a mechanism whereby a health practitioner can follow the wishes of the patient, who is mentally incapable, made at the time when the patient was mentally capable (advance medical directives);
- provides Cabinet with the power to pass Regulations for and to create standard consent forms for specific treatments; and
- provides for emergencies when health services can be provided without consent.

Bill 108, Substitute Decisions Act, 1991, pertains to individuals with long-term incapacity. It implements the concept of the living will. Under the Bill, mentally capable persons will be able to choose, in advance, the types of future medical treatment to which they would consent or refuse, and appoint someone to carry out these wishes for them in the event of their incapacity.

The Steering Committee supports the direction the government is taking at the time of this report with respect to consent and substitute decision-making. In the event that these Bills are not proclaimed, or that the elements outlined above are not included, they should be incorporated into the new Public Hospitals Act.

A related issue of consent pertains to the situation of patients in hospitals with teaching programs. Sometimes patients are not aware that they are entitled to consent, or decline to consent, to participate in the teaching activities of the hospital, or that such participation may include being treated by students. It is a matter of balancing diverse interests. The teaching hospital must teach, and to that end patients should be encourage to consent so that students, interns and residents can obtain vital practical

experience. The patient in this situation might be concerned about the consequences of withholding consent, particularly if they are in long-term or chronic care institutions. This type of institution is, for all practical purposes, the patient's home for an extended period of time; and the patient may believe, even if mistakenly, that refusal to cooperate in the institution's teaching activities may affect the level of health services she or he receives.

It can be argued that the patient in the teaching program of the hospital, by virtue of his or her access to the array of expert professionals and sophisticated facilities of the hospital, has a reciprocal obligation to cooperate with and participate in the hospital's teaching functions. It may also be, however, that the patient is in the teaching program of the hospital because other options were not, for practical reasons, available; the patient did not enter the hospital because she or he wanted to participate in its teaching activities. The overriding principle should be that of informed consent. The primary caregiver in the hospital may wish to impress upon the patient the importance of participating in its teaching activities. Patients, however, are entitled to be informed about the right to consent, or decline to consent, to participate in teaching activities including being treated by students; and to be confident that their decision will not affect the quality or quantity of services they receive.

The provision of the information necessary to the patient for informed consent can, and should, take a variety of forms, taking into account the capability of the patient. Clear verbal communications, written materials prepared to several levels of comprehension, and in the more commonly used languages in the community, audiovisual materials and the use of a uniform consent form, are among the variety of means which should be considered. This educational process for the patient about the proposed health service, and the options, reinforces the essential ingredients of informed consent and patient participation in decision-making.

Recommendations

We recommend that:

(9.01) The Government should enact legislation which will:

(a) set out the criteria, requirements and processes with respect to informed consent;

(b) provide safeguards for mentally incapable patients regarding consent to treatment;

(c) establish criteria for legal recognition of advance instructions regarding medical directives, including living wills;

(d) state that patients, including those in long-term and chronic care facilities, must provide informed consent prior to their participation in the teaching or research activities of the institution;

(e) provide criteria for the development of uniform consent forms written in plain language.

(9.02) The Public Hospitals Act should incorporate those elements of Recommendation 9.01 which are not incorporated in separate legislation.

9.2.3 The Use of Restraints

The Public Hospitals Act makes no reference to the use of patient restraints. The Mental Health Act defines "restrain" to include placing the patient under control when necessary to prevent serious bodily harm to the patient or to another person by the "minimal use of such force, mechanical means or chemicals, as is reasonable having regard to the physical and mental condition of the patient".

The Public Hospitals Act should contain similar provisions, to encourage consistent and equitable treatment of the patient regardless of the type of hospital to which the patient has been admitted. The Act should specify that each hospital board pass a bylaw regarding the use of restraints, including at least the documentation in the patient's health record of the following information:

- the use of restraint;
- the method and administration of restraint; and
- the behaviour of the patient leading to the need for restraint.

To assist hospital boards in the development of their bylaws, the Ministry should prepare policy guidelines on the use of restraints.

Recommendations

We recommend that:

(9.03) The Public Hospitals Act should:

(a) require hospital boards to establish a bylaw regarding the use of patient restraints; the bylaw should require, at a minimum, documentation in the patient's health record of the use of restraint, the method and administration of restraints used, and patient behaviour leading to the use of restraints,

(b) define the restraint of a patient to include placing the patient under control when necessary to prevent serious bodily harm to the patient or to another person by the minimal use of such force, mechanical means or chemicals as is reasonable, having regard to the physical and mental condition of the patient.

(9.04) The Ministry of Health should prepare policy guidelines for hospitals on the use of patient restraints.

9.2.4 Confidentiality and Access to Records

At present, the patient's access to her or his medical or health records depends upon where the person was a patient and the provisions of the relevant Act. The Ontario Freedom of Information and Protection of Privacy Act, 1988, governs records held by the provincial government, and includes rules for the collection, use, access and disclosure of personal records, including health records, held by institutions defined by the Act.

Health care records, however, are generally not subject to this legislation because these records are held in agencies - public hospitals, doctors' offices, clinics, nursing homes - which are not directly operated by the government. Also, the clinical records held by the 10 government-operated psychiatric hospitals are specifically exempted from this Act because they fall within the Mental Health Act which contains extensive provisions regarding both confidentiality of patient records, and patients' access to those records. There are also some provisions in the current Regulations under the Health Disciplines Act and the Psychologists Registration Act regarding confidentiality of patients' records. In general, however, the provisions in the various Acts are not comprehensive nor consistent with each other.

The Mental Health Act allows patients much wider access to their health records than do the current regulations under the Public Hospitals Act. Under the current Regulations of the Public Hospitals Act, a hospital board may permit a patient or qualified patient representative, to "inspect and receive information from medical records and from notes, charts and other material relating to patient care and to be given copies therefrom". Under the Mental Health Act, patients have the following rights:

- a patient who is mentally competent is entitled to examine and copy her or his clinical record at her or his own expense;
- the officer-in-charge, upon the advice of the attending physician, may apply to the review board for authority to withhold all or part of the clinical record, and must notify the patient if an application is made;
- the review board shall direct the officer-in-charge to allow the patient to examine the clinical record unless the board is of the opinion that disclosure of the clinical record is likely to result in serious harm to the treatment or recovery of the patient, or serious physical or emotional harm to another person;
- if only part of the clinical record is likely to harm the patient or another person, the review board can exclude that part from review by the patient;

- where a patient is not mentally competent, the person authorized under the Mental Health Act to consent on behalf of the patient is entitled to apply for access;
- a patient who is allowed to examine a clinical record is entitled to request correction of information, to attach a statement of disagreement where the correction is not made, and to require that notice of the correction or notice of disagreement be sent to persons who had seen the clinical record within the previous year; and
- former patients and outpatients have the same rights of access to their records as in-patients.

The patient in a public hospital should have the same rights of access to health records under the Public Hospitals Act as does patient in a psychiatric facility who falls under the Mental Health Act. In practice, there are a number of details to work out: for example, the effort involved in making records available, the retrieval and appropriate cost to the hospital. Charges for the retrieval of health records should not be so high as to constitute an impediment to the individual seeking access, nor so low as to create a financial burden to the hospital.

The Mental Health Act also provides an appropriate model for confidentiality of patient records. The Mental Health Act states that no person shall disclose, transmit or examine a clinical record except in specified circumstances:

- to any person, with the consent of the patient;
- if the patient is not mentally competent, to any person with the consent of the person authorized under the Mental Health Act to consent on behalf of the patient;
- to the officer-in-charge, the physician, persons assessing or treating the patient; or

- to persons involved in research, academic pursuits or the compilation of statistical data, in which case the name and other identifiers of the patient must be removed.

The Ministry of Health has undertaken to address access to and confidentiality of health care information in all settings. A policy framework is under development. Pending new legislation, the Steering Committee believes that the Mental Health Act regarding confidentiality of patients' records and patients' access to those records provides a model that is suitable for the Public Hospitals Act. The Public Hospitals Act should contain provisions, modelled on the Mental Health Act, defining third party access to patient records. Where access is for research purposes, patient identifiers should be removed.

Recommendations:

We recommend that:

(9.05) The Minister of Health should enact legislation which:

(a) protects the privacy of the patient's health records;

(b) allows individuals access to their own health records and own health information;

(c) ensures access to health records for quality improvement activities;

(d) ensures access to health records for research purposes while preserving patient anonymity.

(9.06) The Public Hospitals Act should incorporate those elements of Recommendation 9.05 which are not incorporated in separate legislation.

9.3 LIMITATION PERIOD FOR LIABILITY

It is important that there be a limitation period for hospital liability which is equitable from the perspective of both the patient and the hospital. The Steering Committee has reviewed a number of options and endorses the draft General Limitations Act released on June 27, 1991 by the Ministry of the Attorney General for public consultation.

The draft bill is designed to achieve a new balance between the competing rights of plaintiffs and defendants. Access to justice is enhanced for plaintiffs by ensuring that, as a general rule, their claims are not barred before they have knowledge of them. The defendant's need for certainty is recognized by establishing an ultimate limitation period after which most claims cannot be brought.

Under the draft General Limitations Act, the two-year limitation period under the current Public Hospitals Act. as well as dozens of archaic and often confusing limitation periods, would be replaced with a single limitation period of two years. This would not begin until the plaintiff had sufficient knowledge to commence proceedings. Only if a party did not discover a claim until after 30 years would the claim be finally barred.

A shorter period of ten years, however, would apply to all claims involving negligence of hospitals or hospital employees, as well as all negligence or malpractice claims involving a health professional, subject only to the survival of such claims in the case of incapability or minority (under 18 years of age). This shorter limitation period would not apply, however, to claims based on the leaving of a foreign object, having no therapeutic or diagnostic purpose, in the body of the person with the claim.

Recommendations

We recommend that:

(9.07) The Government should enact legislation regarding limitation periods for liability which:

(a) establishes a single limitation period of two years from the date of discovery of the injury;

(b) establishes an ultimate limitation period of 30 years after the day on which the act or omission on which the claim is based took place, with a shorter limitation period of 10 years for claims involving negligence of hospitals or hospital employees as well as all negligence or malpractice claims involving health professionals except for claims for "retained objects"; and

(c) continues the current law that limitation periods do not run against minors or incapable persons.

(9.08) The Public Hospitals Act should incorporate those elements of Recommendation 9.07 which are not included in other legislation, as they pertain to hospitals.

9.4 A VOICE FOR THE PATIENT

The Public Hospitals Act should provide the patient with the opportunity to seek adjustments or changes in the manner or mode of intervention she or he is undergoing. The current Act does not require the hospital to provide - although many already do - a patient "voice" or "advocate" to assist the patient in dealing with this complex institution. There are hundreds of thousands of patient-provider contacts in Ontario hospitals daily. In a large and complex institution, conflicts are inevitable between the human beings who serve and those being served. The need to obtain or share information is unending. It is to the benefit of both the patient and the hospital that, when such conflicts arise, they be resolved quickly; and that when the need for information arises, it be satisfied quickly.

Three models of patient-advocate or representation were reviewed, represented by the Advocacy Centre for the Elderly; the Psychiatric Patient Advocate Officer; and the Patient Representative used in some general hospitals. The nuances of each mechanism differ, although their objectives are similar. Each is aimed at assisting the patient in her or his encounter in the hospital. Each hospital should have a Patient Services Function (PSF).

9.4.1 The Patient Services Function

The model for a PSF will vary from hospital to hospital depending upon such circumstances as its size, culture and history. However, the PSFs in all hospitals need to share common elements in order to ensure the public of a basic standard of patient services in all hospitals across the province.

The Patient Services Functions should:

- act as a contact point for patient service, provide information to the patient, and receive and facilitate resolution of patients' concerns;
- facilitate patient input regarding service planning and quality;
- assist patients who may have difficulty advocating for their needs and rights; and
- recommend changes in hospital practices and procedures when appropriate, including protecting hospital staff who report objectionable practices involving patients or systemic within the hospital.

The PSF should be part of the internal hospital structure, but function independently of hospital departments. It should have access and visibility throughout the hospital and report directly to the CEO. The PSF should have membership on the Community Advisory Council, on the board committee responsible for quality, and on the management committee responsible for quality improvement.

The PSF will need a protected funding source. This will assist it to maintain its commitment to patient service and to remain independent of internal pressures in the hospital. Funding could be provided directly to the PSF from the Ministry; or be part of an identified and protected portion of the Ministry's annual operating grant to the hospital.

Not all hospitals will be large enough to sustain a PSF. In such cases, alternative arrangements will have to be made: one option is that several hospitals share a PSF; another is that the PSF function be given to someone (or a group) who already has responsibilities in the hospital.

Recommendation:

We recommend that:

(9.09) The Public Hospitals Act should:

(a) set out the responsibilities of the Patient Services Function;

(b) require hospital boards to establish a Patient Services Function;

(c) provide for the independent operation or the Patient Services Function, including a protected funding source; and

(d) ensure protection for staff who complain about objectionable practices in the hospital.

9.4.2 Provincial Advocacy

The PSF will likely be able to attend to the vast majority of issues that might arise from the hospital experience of most patients. There are two types of circumstances in which the PSF may not be sufficient. One such circumstance would be where the PSF was unable to resolve issues for the individual patient in the hospital. A related circumstance would be where the hospital became a party to a lawsuit initiated by the patient, for example, because of alleged abuse by a staff member. A second type of circumstance would be that in which the difficulties faced by the patient were not particular to the patient or hospital, but systemic to the hospital sector generally. In both these types of circumstances a broader and more powerful form of patient advocacy might be required.

The provincial government has initiated Bill 74, the Advocacy Act 1991. The Bill is designed to accommodate case, legal and systemic advocacy, and appears to include hospital patients within its scope. In the circumstances, it is preferable to ensure that the

provisions of this proposed legislation are accessible to persons in public hospitals than to develop a separate independent advocacy system within the boundaries of the Public Hospitals Act.

Recommendation:

We recommend that:

(9.10) Legislation should ensure that persons in public hospitals have access to the proposed provincial advocacy service.

Chapter 10 PROVINCIAL RESPONSIBILITIES

10.1 INTRODUCTION

Under the Ministry of Health Act and Regulations, the Minister of Health is responsible, among other tasks, for the development, coordination and maintenance of comprehensive health services and a balanced and integrated system of hospitals and other health facilities in Ontario; (s.6.1.c); governing the care, treatment and services and facilities provided by hospitals and health facilities and assessing the revenues required to provide such care, treatment and services; (s.6.1.g); and inquiring into and determining the hospital and health facilities, services and personnel required to meet the health needs of the people of Ontario (s.6.2.a)

The Public Hospitals Act gives the Minister specific responsibilities regarding the organization and operation of individual hospitals; and the Legislature is responsible for approving the funding for hospitals.

There is, however, no description in legislation or regulation of what is meant by a comprehensive, balanced and integrated system of health care facilities and services; what the form and objectives of the provincial system are; or of the provincial framework, objectives and guidelines which hospitals are to follow to create balance and integration. There is no reference to the specific obligations of the Minister for developing or operating the integrated system within which the hospital operates, or to the procedures and operations through which this will happen.

There is a need for legislation which provides the foundations for a forward-looking and integrated provincial system of hospital and health care facilities. The legislation should set out the responsibilities of the government, the hospital and the intermediate agencies, such as district health councils, with respect to the development and provision of hospital and other programs, services, treatment and care; and the processes for negotiations and making decisions. Within such a

legislative framework, the Minister would establish policy objectives and guidelines within which the hospital could develop its social contract and discharge its responsibilities to the government.

The three major areas in which the province needs to define its roles, responsibilities and operating mechanisms are planning, funding and regulating. There is also a need for clarity around provincial responsibilities for alteration of services.

10.2 PROVINCIAL PLANNING FRAMEWORK FOR THE HEALTH CARE SYSTEM

Given the range and diversity of interests in the health sector generally, and the hospital sector specifically, it would be unrealistic to recommend that the provincial government develop a "hospital plan" for the province. It is not clear what such a plan would contain, who would be parties to it, or if and when agreement on it would be possible. In place of a provincial plan, the provincial government should establish health goals or objectives and priorities; provide funding and other incentives to encourage the stakeholders to cooperate with each other; and put in place machinery through which the issues can be worked through in keeping with provincial objectives. This approach may lack the seeming tidiness and clarity of a "plan". But, experience suggests that this approach will work better.

It is important, therefore, that the Minister develop health goals and priorities, and planning legislation through which these can be achieved. The legislation would likely be separate from the Public Hospitals Act, and include the necessary components of the provincial health care system. With respect to the hospital sector, the legislation needs to encompass three subjects: Ministry roles and responsibilities; the structure and process of planning, and the roles and responsibilities of the district health councils and other planning authorities.

10.2.1 Ministry Roles and Responsibilities

The planning legislation should regulate and give direction to integrated planning throughout the health care system. It should be based on provincial health goals, and specify the roles and responsibilities of the Ministry. The legislation should also set out the procedures for the development and operation of a "balanced and integrated system of health facilities and services in Ontario".

The legislation would articulate what the government, acting on behalf of the public, expects of the hospitals and other facilities, agencies and individual providers who make up the whole of the health care system; the roles and responsibilities of the hospital sector; and the relationship of the individual hospital to the wider system.

10.2.2 Structure of the Planning Process

Public hospitals should be required to conduct their long-range planning and establish their social contracts within the context of a coordinated, integrated and balanced system of health services and facilities. There are, however, no clear guidelines for the hospital to follow regarding the parties to be included in the planning consultations, the nature of the consultations, or the processes through which differences can be resolved.

Local conditions and practices vary so widely across the province, the Ministry should specify in legislation at least the minimum standards which the planning process must meet. The hospital board needs some criteria by which it can ascertain whether it has met its responsibilities for coordination and collaboration in the hospital's planning and development of programs and services.

The proposed legislation should specify the planning process, including:

- what the plans and social contract are to encompass;
- criteria by which to identify participating stakeholders;
- mechanisms for carrying out coordinated planning;

- processes for obtaining approval for new services or programs, and altering existing ones;
- processes through which hospitals can resolve their requirements in the context of the plans and aspirations of other hospitals and other health facilities in the district; and
- coordination of the services and operations of individual hospitals, and other health facilities, in a locality to create regional and province-wide programs.

10.2.3 The Role of the District Health Council and Other Intermediate Agencies

There is a need for intermediate planning and coordinating agencies between the individual hospital and the Ministry. The district health council is one such intermediate instrument through which district planning can be coordinated, and the Minister advised on district planning matters. In addition to district health councils, there may be a need, in some parts of the province, for regional or area planning councils which include several district health councils. Legislation should be explicit that planning and coordination are part of the mandate of district and regional agencies.

District health councils, and other intermediate planning agencies, as may be established, require guidelines from the Ministry on how to carry out their responsibilities: the structure and mechanisms through which their coordination should take place; and the processes they should institute to ensure and demonstrate that all appropriate stakeholders have been included in the process. District health councils will also need guidance on how to deal with issues around agreement and disagreement amongst the various parties: what degree of agreement needs to be achieved for both the hospital and the council to be satisfied that each has met its obligation to achieve coordinated, collaborative and integrated planning; what degree of disagreement among the parties can be accommodated before the district health council has to advise the Minister that it cannot facilitate an agreement between the hospital and its community.

Under the current health insurance program, almost all hospitals are public institutions. A few, however, are not; and there are other private health services such as laboratories, radiology clinics, community health centres and other independent health facilities which may provide hospital-type care. The organization of health services is changing. This report takes no position on the desirability of an increase or decrease in the number of private hospitals. It is important, however, from the perspective of provincial and local planning and coordination, that private health services participate in local planning and that the proposed planning legislation include both public and private facilities and services within the mandate of the district health council.

In the event that new planning legislation is not developed, the Minister should develop policy guidelines with respect to health sector planning and coordination, including hospitals.

Recommendation:

We recommend that:

(10.01) The Ministry of Health should enact legislation which mandates coordinated and integrated planning at the district, regional and provincial levels, and applies to the public and private sectors of the health care system.

10.3 FUNDING

The issues around provincial funding pertain to: the structure of the funding process, limitations on operating funding, discussed in Chapter 6; to capital funding; and to criteria and procedures to assist the province and the hospital to fulfill their respective responsibilities for the expenditure of public funds.

10.3.1 Operating Funds

Currently, the Ministry funds most of the operating costs of the hospital. These funds are provided on a global basis for each fiscal year. Each hospital is expected, with some exceptions, to carry out all its operations for that fiscal year

within that global amount, plus whatever revenues the hospital may raise from other sources. This approach has the advantage of fixing the provincial funding commitment while giving the hospital the freedom and flexibility to use its funds as it deems best to meet its local requirements.

The global budgeting approach should be retained. It would be unwise to institute a funding system driven solely by the volume of the hospital's services. Such a system would remove the province's ability to control the amount of public funds devoted to hospital operations and diminish the hospital's incentive to control its utilization of resources. Even so, it would be helpful, as an enhancement to current allocation methodologies, to take into account changes in a hospital's population, volume, case mix and activity so as to encourage a greater degree of consistency and fairness in the allocation among hospitals of provincial funding for operations.

Provincial Contracts. The public hospital can be a powerful tool to achieve specific government health and economic objectives which may not be regarded as falling within the hospital's global funding. The new Public Hospitals Act, therefore, should authorize the Ministry to develop contracts with individual hospitals and intermediate agencies that direct funding to meet specified district, regional or provincial objectives. This authority should enable the Ministry to specify the types and volumes of services it requires of the hospital in return for the funding; and the hospital to negotiate the price it charges for each unit of service. Such a process can play an important role in the hospital's long-term financial planning and in the achievement of specific provincial program and service objectives.

Recommendation:

We recommend that:

(10.02) The Minister of Health should be authorized to contract with individual hospitals and intermediate agencies to obtain specific service outputs for regional or provincial programs.

10.3.2 The Supply Act

In the discussion of issues around operating and capital funding, it is important to keep in mind the requirements the Minister must meet with respect to the allocation of funds as set out in the Estimates of the Legislature.

The payment of operating and capital grants to hospitals by the Ministry of Health is authorized through the Estimates process. "Estimates" are the written estimates of the amount of money that will be required by the various ministries and offices of government to undertake and finance the programs and policies of the government for the fiscal year to which those estimates apply.

Following a review process, the Estimates are approved by the Legislature through the annual Supply Act. The Act provides for the payment out of the Consolidated Revenue Fund of the amounts in the Estimates for each ministry. The Supply Act requires that the expenditures authorized by the Act be applied only in accordance with the votes and items of the Estimates, and Supplementary Estimates, upon which the schedule is based.

Thus, the authority for the transfer of provincial funds to hospitals is not the Minister of Health but the Legislature through the Supply Act. The Supply Act requires that the Minister use the funds for the purposes for which they were voted. The Minister of Health is not authorized to allow funds designated in Estimates for operating funds to be used for capital purposes, or capital funds for operating purposes.

Multi-Year Funding. The effective management of hospital resources, long-range planning and social contracts with long-term program, service and funding implications, requires that hospitals be able to carry out fiscal planning and management on a multi-year basis. Their need for long-term fiscal predictability will increase as more of them enter into social contracts with long-term commitments for programs and services for patients, the community, education and research.

The Supply Act, however, provides for funding only on an annual basis. Historically, the provincial government has not made large multi-year funding commitments to hospitals which are binding on the province regardless of election results or other circumstances. Practically speaking, however, provincial funding to hospitals has been fairly predictable from year to year. The requirement for multi-year funding commitments only makes explicit that which is already implicit in provincial funding behaviour. The basic issue is that, to manage effectively and efficiently, hospitals have to plan; and this means they have to be able to predict their funding over a longer time period than they can currently. Given the province's typical funding behaviour, the gap does not appear to be impossible to bridge.

Recommendation:

We recommend that:

(10.03) The Government should take steps to facilitate multi-year fiscal planning by the hospitals.

10.3.3 Capital Funding

The Ministry of Health is the largest single source of a hospital's capital funding. Typically, the Ministry will provide up to two-thirds of the costs of a hospital's capital program; more in smaller Northern Ontario communities (this does not include equipment replacement). Currently, the Ministry exercises the right of approval for all proposals for hospital development, redevelopment and renovation. From the Ministry's perspective, the issue is primarily money. The hospital's capital projects often lead to higher operating costs; the province's resources are limited and, therefore, it involves itself at the micro level in the approval of individual capital projects. The hospital, however, seeks a greater degree of flexibility and autonomy in its expenditure of capital funds in order to meet local needs.

A balance needs to be struck between the two interests. It is not in the public interest that the full exercise of Ministry scrutiny be brought to bear on every minor capital project. But, it is in the public interest that the Ministry ensure that capital

projects are wisely conceived, and do not lead to higher than agreed-to operating costs, or to unapproved changes in the hospital's social contract with the community.

The Public Hospitals Act should require Regulations establishing thresholds for those capital expenditures which require approval. The guiding principle for these Regulations should be that, providing that the hospital's long range and operating plans are approved by the Ministry of Health, the Regulations permit, within defined thresholds and without further approval by the Ministry of Health:

- minor modifications that do not substantially alter services;
- financing plans that do not expose the hospital to substantial financial risk by jeopardizing the viability of the hospital; and
- freedom to use funds for capital purposes within the context of approved plans.

Recommendation:

We recommend that:

(10.04) The Public Hospitals Act should require regulations to be set which define the scope of capital projects which do not require approval by the Ministry of Health.

10.3.4 Authority to Fund

The current Act provides the Minister with the authority to provide aid to hospitals, as set out in the Regulations. The Regulations, however, are silent with regard to operating grants. The Minister's authority to allocate operating funds to individual hospitals resides in the Ministry of Health Act and the Health Insurance Act. It would be more appropriate to locate that authority in the Public Hospitals Act.

A related issue is program-directed operating funds. The new Public Hospitals Act should specify the Minister's authority to grant operating funds to hospitals and other agencies for identified patient programs, research, education and related

activities. Although the Minister does make these grants, it would be helpful to have her authority articulated in the Public Hospitals Act.

Recommendation:

We recommend that:

(10.05) The Minister of Health should have the authority to grant operating funds to hospitals, and other agencies, for specified patient programs, research, education and related activities.

10.3.5 Appeals

The hospital has two grounds on which it can argue its case for a change in the amount of its global funding. It can dispute the basic premises the Ministry has used in establishing the global amount, or it can argue that the Ministry has erred in its calculations or made a technical error of some kind. We are not suggesting that the hospital should have the right to appeal the adequacy of its global funding allocation; however, hospitals should have a defined process through which to appeal their funding allocation on very narrow technical grounds (the formula is faulty) or because of statistical errors.

A fair appeals process requires reliable and consistent information and reporting from hospitals. Currently, inconsistencies in reporting can result in funding allocations that benefit some hospitals more than others. In the interests of fairness and efficiency the Minister should specify reporting standards.

Another issue related to appeals is the timing of the Ministry announcements for the hospital's annual operating grant. These announcements are often made after the hospital has made its program and service decisions for the current fiscal year; sometimes the announcements are made after the fiscal year has begun. This can lead to uncertainty and to delays in programs and services. The hospital has little opportunity to appeal. Sometimes, delays in the Minister's announcement of annual

operating grants arise out of broader funding issues. Nonetheless, it is likely that the current situation can be improved.

Recommendations:

We recommend that:

(10.06) The Minister of Health should establish, in consultation with hospitals, a formula which enhances the current approach to allocating provincial funds among hospitals, takes into account service volumes, case mix, changing circumstances in the community and other relevant matters, and is fair and consistent.

(10.07) The Minister of Health should establish regulations setting out the technical grounds on which hospitals can appeal their funding allocations.

(10.08) The Minister of Health should establish time frames for the allocation of funds to hospitals that support sound planning and management processes.

10.4 ALTERATION OF SERVICES

Changing demographics, unexpected case mix and other unforeseen circumstances can require a hospital to alter its services. Currently, proposals for service alteration are handled by the Ministry. The Ministry takes into account the hospital's current package of services, the advice of the district health council on the needs of the area, the services and proposals of other hospitals in the area as well as its own budget. In the future, the hospital's proposals for change might require changes to its social contract or other undertakings. The procedures for handling the hospital's proposal for the alteration of services specified in the social contract, or in other undertakings, should be set by the Ministry and incorporated into each social contract. The implementation of appropriate procedures will simplify and clarify what is now an uncertain process which often consumes unnecessary amounts of time and effort.

Recommendation:

We recommend that:

(10.09) The Minister of Health should specify the circumstances and processes to be followed by the Minister and the hospital regarding alteration of hospital services, taking into account the hospital's social contract and the affected parties.

10.5 INTER-HOSPITAL ORGANIZATIONS

Inter-hospital organizations extend from voluntary collaboration to corporate mergers. The Public Hospitals Act is silent on questions of inter-hospital organizations such as federation, mergers and partnership, save that the Minister's approval is required to establish new hospital corporations.

The Public Hospitals Act should enable hospitals to merge, join clinical programs or services, or create new organizations. Depending on the scale and significance of the proposed inter-hospital activity, it might be subject to Ministry approval. Similarly, the Minister of Health should have the authority to direct given hospitals in

certain circumstances to work together in formal organizational structures. This authority would reinforce the fundamental principle that all public hospitals form components of a 'public system' of hospitals, the purpose of which is to serve the public interest and agenda; and that the Minister is responsible for that system.

There are a number of considerations that should underlie a legislative approach to those circumstances when there is a need for hospitals to collaborate but are unable or unwilling to do so. These considerations include:

a) inter-hospital collaboration should be facilitated and accomplished voluntarily by the hospitals;
b) where not accomplished voluntarily, inter-hospital collaboration should be required under the terms of the Public Hospitals Act;
c) any compulsion to inter-hospital collaboration should be exercised by the government only as a last resort, after incentives favoring collaboration have failed to work at a local and regional level; and
d) the advice of local, district, and regional planning authorities should be sought by individual hospitals and the Ministry of Health for the most effective and sensible ways of achieving inter-hospital collaboration.

In line with these considerations, a range of policy instruments should be specified in the Public Hospitals Act to foster and direct inter-hospital collaboration. Four levels of collaborations are envisaged.

10.5.1 Coordination of Social Contracts

The first such policy instrument would be the Ministry's requirement that individual hospitals develop their social contracts so that each contract relates to those of the other hospitals, and to the responsibilities of other institutions, providing health services to the community. District health councils, and regional planning authorities that may be established, should have the authority from the Ministry to facilitate the coordination of the various social contracts which fall within their respective ambits.

We have already recommended that every hospital's social contract should be signed by the Minister of Health, as representative of the hospital's composite community, upon receipt of advice from the hospital and the relevant district health council or regional planning authority. We can foresee linkages between approval of a hospital's social contract and provincial approval of its budget and plans relating to its operation and financing.

The social contract is a powerful incentive for inter-hospital collaboration. This instrument will likely be sufficient, in the great majority of cases, to bring about sensible rationalization of hospital services. Hospitals providing services to the same communities will usually find it in their best interest to form voluntary organizations or associations to facilitate conjoint planning. This is by far the most desirable way to promote collaboration among public hospitals (and, indeed. among all manner of organizations and individuals in the health system).

10.5.2 Partnership or Joint Venturing among Public Hospitals

A second policy instrument would involve a higher level of organization beyond the voluntary association. The partnership or joint venture is seen as a formal agreement among individuals or organizations to pool their efforts to achieve objectives of mutual interest and benefit.

The Partnership Act defines a partnership as "...the relation that subsists between persons carrying on a business in common with a view to profit". Clearly, this is not

a definition applicable to public hospitals. We conceive an analogous relationship, however, between or among hospitals with complementary, mutually reinforcing social contracts. They may want to develop formal linkages with more capacity than a voluntary association for binding decision-making, but which stop short of a formal merger of their corporate entities.

Such partnerships or joint ventures would likely be based on a time-limited contractual understanding that each of the 'partners' will be bound by collective decisions arrived at in accordance with clearly defined and well understood decision-making processes; such decisions typically being restricted to previously agreed topics or spheres of responsibility regarding particular services or objectives. Some hospitals may choose partnership agreements or joint venturing as a logical extension of voluntary association in order to give a higher degree of procedural formality to their mutually-supported decision-making structure. Where such partnerships or joint ventures are proposed, they should be subject to review by the Minister of Health on the advice of the district health council, or regional planning authority, taking into consideration the implications for the partners' social contracts and the coordination and integration of services in the district or region.

The Public Hospitals Act should also provide authority to the Minister to require the sharing of services on a 'partnership' or joint venture basis, on the recommendation of a district health council or other planning body. The Minister should also have the authority to require a joint venture in circumstances where one of a given group of hospitals is reluctant or refuses to participate and such participation is perceived to be in the public interest. In any of these circumstances, the Minister would have the authority to fund the activities of the partnership or joint venture, for example, a common laboratory, computing facility or base hospital.

10.5.3 Federated Systems with Separate Boards of Directors

A progressively more formal type of organization, proceeding past the voluntary association and the joint venture or 'partnership', is the federated system. In this

arrangement, a group of organizations, each with its individual board of directors, agrees to cooperate in defined spheres of activity, and creates a new, federated board to provide governance over matters in these defined spheres agreed to by the individual organizations.

An essential step in forming a federated system is the establishment of the new federated board. Although, logically, the new board would represent a new corporation, it need not do so; the new board could exercise powers delegated to it by the members of the federation. The basis of the federation would be an agreement among its members with respect to those powers to be consigned to the federated board and those to be retained by the member boards.

Despite its potential problems, the federation, as an organizational form to promote inter-hospital collaboration, does offer merit in some circumstances. One advantage is that a federation can be created for a limited time, charged with establishing collaboration of limited scope, for example, the development of integrated clinical or administrative services. Another advantage is that the authority of the federation can be closely described and limited by its letters patent or constitution. Yet another advantage is that the federated board can be held directly accountable for the discharge of its responsibilities, without that accountability resting directly on the individual member corporations. If the federation covers a wide range of programs, it is probable that the involved organizations would be better served by a full-scale merger.

We recognize that federations can cause problems, most notably if they remove from the boards of the founding organizations essentially all power and responsibility, rendering them 'empty' organizations. This danger should be recognized from the outset by members of a proposed federation. The reverse can also be true. A federated Board must be given useful work to do and sufficient authority to do it. Otherwise, there would be no point to forming the federation. Care must be taken to preserve a balance between the responsibility and authority

of the federation and the responsibility and authority of the individual member boards.

The federation approach is likely suited best to programmatic collaboration among member hospitals, for example, to create and operate multi-hospital geriatric services or cardiac surgery. Although federated systems could be imposed on unwilling hospital boards, they will be most successful if they are formed voluntarily and serve ends considered desirable by all of the member institutions.

10.5.4 Mergers

At present, the Public Hospitals Act requires agreement of the Minister of Health for the formation of all new corporate organizations with responsibility for public hospitals. Because federated systems could, and mergers would, result in the establishment of new corporations with their own boards, this continuing legislative requirement would provide the Minister with sufficient authority to prevent the creation of bodies that, in the opinion of the Minister, were not in the public interest.

As well as preventing mergers, there could well be circumstances in which the Minister of Health should have authority to direct the merger of two or more public hospitals. In the interest of equity, the Minister's power to direct hospital mergers should be constrained by processes involving decision-makers in the community, district and region to ensure that the public interest would be genuinely served by such a merger. Such processes should involve district health councils and regional planning authorities, and should provide the potentially-affected hospitals with generous opportunities to present their cases for and against the merger (or federation or joint venture) in a forum that would permit participation by the affected public.

Action by the Minister to force a merger should be exercised under two conditions:

1) there is clear evidence that the processes relating to voluntary coordination of the social contracts of affected hospitals have failed to produce collaboration; and

2) the proposed merger is clearly in the public interest as determined by a process approved by the Minister and involving the district health council or regional planning authority, to ascertain that interest.

Recommendation:

We recommend that:

(10.10) The Public Hospitals Act should authorize the Minister, under specified conditions, to require formation of a joint venture or partnership, a federation with a new board of directors or a merger of hospitals.

10.6 REGULATIONS

Much of the implementation of legislation - how it works and the procedures - is set out in Regulations. The Lieutenant-Governor in Council (Cabinet) has the right to issue Regulations without consulting the affected parties. In practice, consultation often does take place: sometimes on a systematic basis; sometimes less formally. Sometimes Regulations are issued in a faulty form which might have been corrected if a more extensive or appropriate consultation had taken place.

It is reasonable for the new Public Hospitals Act to require the Minister to consult with hospitals and other stakeholders prior to the amendment of Regulations or the development of new ones. This requirement would not affect the right of Cabinet in emergency situations to issue Regulations without consultation.

Recommendation:

We recommend that:

(10.11) The Minister of Health should consult with hospitals and other stakeholders prior to amendments to, or development of new regulations, except in emergency situations where delay is not in the public interest.

10.7 RESPONSIBILITY FOR QUALITY

The individual hospital is responsible for the quality of the care and services it provides its patients. It is not likely that this can or should change. No one else is in a better position to ensure quality in the hospital than the hospital itself.

Given the wide variations among hospitals in quality improvement programs, the Ministry can assist the hospitals through a dedicated effort or organization to promote, coordinate and provide leadership in education, research and trans-professional development in quality assurance and management.

The public has a strong interest in ensuring that quality assurance and quality management activities in each hospital meet some reasonable minimum standards. The Ministry can assist in this regard by issuing, after appropriate consultation, Regulations regarding quality of care and service in the hospital.

Recommendations:

We recommend that:

(10.12) The Public Hospitals Act should provide for the development of Regulations concerning the quality of care and service in the hospitals.

(10.13) The Minister of Health should consider establishing an institute to promote, coordinate and provide leadership in education, research and professional development in the management and improvement of health care services.

10.8 INVESTIGATIONS

Because hospitals are public institutions, the Minister should be empowered to monitor hospital activities and to intervene when necessary. Under the current

Public Hospitals Act, Cabinet can appoint one or more persons to investigate and report on the quality of the management and administration of a hospital, and the quality of the care and treatment of patients in the hospital. This broad authority should not change in the new Act. It would be contrary to public interest to attempt to define too closely or to limit the discretionary authority of Cabinet to intervene when it considers it necessary.

Under the current Act, the Minister is required to provide a copy of the investigator's report to the hospital board. As a matter of equity, the new Act should specify the right of the hospital to receive a copy of the investigator's report at the time it is filed with Cabinet, and the right to submit a response within a reasonable time limit if it chooses to do so. The new Act should require Cabinet to take that response into account in its deliberations. The new Act should also specify the time period within which the hospital must respond, so as not to delay unduly the ability of Cabinet to make the necessary decision. As a matter of public interest, the new Act should also specify that in emergency situations the Cabinet can act before receipt of the hospital's response to the investigator's report.

Recommendations:

We recommend that:

(10.14) The Public Hospitals Act should provide for the regulation of hospitals by the Minister through review of performance and intervention when necessary to protect the public interest.

(10.15) The Public Hospitals Act should preserve the discretionary authority of Cabinet to appoint Investigators where there are concerns with regard to the quality of governance, management, treatment or care in the hospital.

(10.16) The Public Hospitals Act should require the Minister to provide a copy of the Investigator's report to the chairman of the board of the hospital upon the filing of the report with Cabinet.

(10.17) **The Public Hospitals Act should stipulate that hospitals have a right, except in emergency circumstances, to make representations to Cabinet with respect to the report of the Investigator prior to Cabinet decision.**

Appendix I

Membership

Public Hospitals Act Review

Steering Committee Membership

Dr. Ted Broadway
Director, Health Policy
Ontario Medial Association
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Dr. Tom Dickson
Physician
Ontario Medial Association
Brampton

Janet Ecker (eff. September 1991)
Director
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of Ontario
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Rick Edwards
Community Health Advocate
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Peter Ellis
President
Sunnybrook Health Sciences Centre
Toronto

Fred Griffith, B.A. O.D.
President Emeritus
Group Health Centre
Sault Ste. Marie

Dave Innes, Q.C.
Trustee
Sudbury Memorial Hospital

Jay Kaufman (resigned Chair, June 1991)
Secretary of Treasury Board,
Former Assistant Deputy Minister
Ministry of Health

Jane Kilthei
President-Elect
Association of Ontario Midwives
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Shirley Laforme
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J. Douglas Lawson, Q.C.
Past Chairman
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Mary Catherine Lindberg
Assistant Deputy Minister
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Patricia McGee
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Ministry of Health

Barry M. Monaghan
President and CEO
West Park Hospital
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Margaret Risk
Executive Director
College of Nurses of Ontario
Toronto

Mark Rochon
President
Humber Memorial Hospital
Weston

Ron Sapsford (Chair, eff. June 1991)
Director, Community Hospitals Branch
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Dr. Duncan Sinclair
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Barb Stuart, R.P.Dt.
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Ontario Dietetic Association
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David Coburn (resigned Feb. 1991)
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Dr. Tony Shardt (resigned June 1991)
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Glenna Cole Slattery (resigned May 1991)
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Research Advisor: Jane Fulton, Ph.D.
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Legal Branch

Task Groups

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Dr. Duncan Sinclair (Chair)
Peter Ellis
Jay Kaufman (resigned June 1991)
Ron Sapsford (eff. June 1991)

Dr. Ted Boadway
Dave Innes
Doug Lawson
David Coburn (resigned Feb. 1991)

Utilization and Effectiveness

Mary Catherine Lindberg (Chair)
Shirley Laforme
Dr. Emerson Woodruff

Dr. Tom Dickson
Dr. Tony Shardt (Resigned June 1991)

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Beth Johnson
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Sunnybrook Health Sciences Centre

Jenny Wong
Quality Management
Ministry of Health

Sister Winnifred McLoughlin
Executive Director
Sudbury General Hospital

Management, Planning and Funding

Mark Rochon (Chair)
Ron Sapsford

Fred Griffith
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Rick Edwards (Chair)
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Additional members

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Hospital-Professional Relationships

Barry J. Monaghan (Chair)
Jane Kilthei

Patricia McGee
Verna Steffler

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Dr. Ted Burge
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Dr. Hugh Curry
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Peterborough Civic Hospital

Dr. David Evans
Psychologist
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Marel Fielding
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Dr. Peter Granger, V.P.
North York General Hospital

Susan Newman, R.N.
College of Nurses of Ontario

Dr. Brian Ridgely
Psychologist
Sunnybrook Health Sciences Centre

Appendix II

Submissions

Submissions to the Steering Committee

Name of organization or individual

Association of Ontario Health Centres
Association of Ontario Midwives
Association of Ontario Midwives, Legislation Committee
Association of Treatment Centres
Board of Directors of Chiropractic, Province of Ontario
Canadian Physiotherapy Association
Canadian Society of Hospital Pharmacists, Ontario Branch
Canadian Union of Public Employees, St. Catharines
Citizens for Fiscal Responsibility in Hospitals
College of Nurses of Ontario
Collingwood General and Marine Hospital
Douglas Memorial Hospital, Dr. R.S.H. Twidle, Chief of Staff, Fort Erie
Hospital Auxiliaries Association of Ontario
Hospital Council of Metropolitan Toronto
Hotel Dieu Hospital Volunteer Services, Kingston
Interim Regulatory Council on Midwifery (2 submissions)
Kingston General Hospital and Auxiliary
Kingston, Frontenac & Lennox & Addington District Health Council
Ontario Association of Medical Radiation Technologists
Ontario Association of Optometrists
Ontario Association of Radiology Managers
Ontario Association of Registered Nursing Assistants
Ontario Association of Speech Language Pathologists & Audiologists (2 submissions)
Ontario Chief Psychologists Association
Ontario Chiropractic Association
Ontario College of Pharmacists
Ontario Council of Teaching Hospitals (3 submissions)
Ontario Dental Association
Ontario Dietetic Association
Ontario Hospital Association (2 submissions)
Ontario Medical Association (2 submissions)
Ontario Nurses' Association
Ontario Psychological Association (2 submissions)
Ontario Public Health Association
Ontario Society of Occupational Therapists
Patients' Rights Association
Provincial Association of Chairmen of District of Health Councils of Ontario
Registered Nurses' Association (2 submissions)

Royal Ottawa Health Care Group, Royal Ottawa Hospital
Scarborough General Hospital, Medical Staff Association
Service Employees International Union
Stevenson Memorial Hospital, Alliston
The Association of Nurse Executives of Metropolitan Toronto
The Belleville General Hospital Auxiliary
The Belleville General Hospital, President of Medical Staff
The Board of Directors of Physiotherapy
The Brockville General Hospital Auxiliary
The College of Physicians and Surgeons of Ontario
The Council of Ontario Faculties of Medicine (2 submissions)
The Mississauga Hospital
The Ontario Board of Examiners in Psychology
The Riverdale Hospital, Chief & President of Medical Staff, Toronto
The Royal College of Dental Surgeons
Thunder Bay District Health Council
University of Toronto, Faculty of Medicine, Dr. J.L. Provan

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